

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 77

63458

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH: Baltimore  
 County.....  
Catonsville  
 City or town.....  
 (If outside city or town limits, write RURAL and give nearest town)  
25 yrs.  
 How long in above place of death?  
 Hospital, institution, or street address where death occurred:  
638 Ingleside Ave.  
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)

State..... Md. County..... Baltimore  
 City or town..... Catonsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. .... 638 Ingleside Ave.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war..... World War I

## 3.(a) FULL NAME

Henry Lewis Alsobrook

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
<u>Male</u>	<u>White</u>	<u>Married</u>

6.(b) Name of husband or wife..... Celestine F. Alsobrook

7. Birth date of deceased (mo., day, yr.) Aug. 21, 1898.

8. AGE:	Years	Months	Days	If less than one day
	<u>47</u>	<u>7</u>	<u>11</u>	.... hrs. .... min.

9. Birthplace..... Florida  
 (Town, county, and state)

10. Usual occupation.....

11. Industry or business A. T. & T. Co.  
 Father..... Thomas Godwin Alsobrook

Mother..... Greenwood, Fla.

Mother..... Anna Hensler  
 15. Birthplace Marianna, Fla.

16. Informant Mrs. Celestine Alsobrook  
 Address 638 Ingleside Ave.

Burial  
 17. (Burial, cremation, or removal. Which?) Baltimore National  
 Date thereof April 6/46.  
 (month) (day) (year)

Cemetery or crematory..... Baltimore National

Location ..... Frederick Rd. Baltimore, Md.

18. Funeral director Harry H. Hutchins  
 Address 4101 Edmondson Ave.

19. 4-5 1946 Harry H. Miller  
 (Date rec'd by registrar) Registrar

3. (b) Social Security Number  
212 03 5031

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 2/46. 19..... at..... 7:30 P.M.

21. CERTIFY that death occurred on the date above stated; that I attended deceased from Several years 19..... to 19..... April 2 - 19..... April 6  
 and that I last saw him alive on April 2 19..... to 19..... April 6

Immediate cause of death General arteriosclerosis &  
wasting away of body - DURATION 1 1/2 yrs

Due to Raynaud's disease 2-3 yrs

Due to Arteriosclerosis ?

Other conditions Gangrene of feet 6 mos  
Legs (Indicate pregnancy within 3 months of death)

Major findings of operations..... Date of op. ....

Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE E. E. Nichols M.D. M. D. or other \_\_\_\_\_

Address Pikesville Md Date signed 4-8-46



Evidence for change of age MARYLAND STATE DEPARTMENT OF HEALTH  
of deceased is shown on

2411 N. Charles St., Baltimore 462

FILM No. 101 APR 29 1946

## CERTIFICATE OF DEATH

13459 32  
Reg. Dist. No.

## 1. PLACE OF DEATH:

County.....

Baltimore

City or town.....

Pikeville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

50 yrs.

Hospital, Institution, or street address where death occurred: \_\_\_\_\_

How long in hospital or institution?.....

—

## 3. (a) FULL NAME

Amos Wesley Armacost Sr.

## 3. (b) Social Security Number

218-09-9321

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male

white

married

6.(b) Name of husband or wife.....

Ruth Blaine Armacost

6.(c) If alive, give age ..... years

7. Birth date of

deceased (mo., day, yr.)

Oct 2 - 1865

8. AGE:

Years  
--81- 80Months  
6Days  
20It less than one day  
..... hrs. ..... min.

9. Birthplace.....

Baltimore Co. Md

(Town, county, and state)

10. Usual occupation.....

Balto Transit Co.

11. Industry or business

Wm Armacost

12. Name.....

Upperco. Balt. Co. Md

13. Birthplace

Rachael Armacost

14. Maiden name.....

Baltimore Co. Md

15. Birthplace

Mrs. Ruth B. Armacost

16. Informant.....

Address 10 Old Court Rd. Pikeville Md

Burial

Date thereof April 25-46

(Burial, cremation, or removal. Which?)

Cemetery or crematory.....

Daniel Ridge

Location.....

Pikeville - Maryland

18. Funeral director.....

Frank A. Young

Address.....

Pikeville - Maryland

19. Apr 24

(Date rec'd by registrar)

1946

E. Nichols

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State.....

Maryland County.....

Baltimore

City or town.....

Pikeville (If outside city or town limits, write RURAL and give nearest town)

Street No.....

10 Old Court Rd. (If rural, give LOCATION)

2.(a) If veteran, name war.....

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....

April 22 1946 at 71 V.P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov 6 - 1944 to April 22 1946

and that I last saw him alive on April 21 - 1946

Immediate cause of death.....

Carcinoma of liver 2 yrs

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury..... Injured at work?

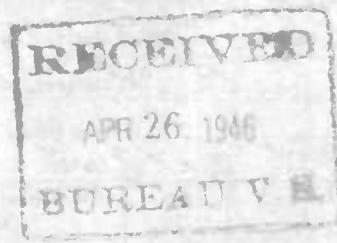
23. SIGNATURE.....

I.D. or other

Address.....

Pikeville &amp; my Date signed Apr 26-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 2020

03460

Reg. Dist. No. 30

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH:

County..... Balto.

City or town..... Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Hood Nursing Home - 5501 Edmondson Ave.

How long in hospital or Institution?

## 3. (a) FULL NAME

FLORA G. BANDEL

4. Sex      5. Color or race      6.(a)Single, married, widowed, or divorced

Female      White      Widow

6.(b) Name of husband or wife..... Lyttleton C. Bandel

7. Birth date of deceased (mo. day, yr.) Nov. 27, 1877      6.(c) If alive, give age ..... years

8. AGE:      Years      Months      Days      If less than one day  
68      4      20      hrs.      min.9. Birthplace..... Baltimore, Md.  
(Town, county, and state)  
Housewife

10. Usual occupation.

11. Industry or business

12. Name..... William H. Gahan

13. Birthplace..... Ireland

14. Maiden name..... - Powell

15. Birthplace..... England

16. Informant..... Mrs. J. M. Behr, daughter  
Address 489 Kenwood Ave., Delmar, N. Y.17. Burial Date thereof..... 4/20/46  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory..... Druid Ridge Cen.

Location..... Pikesville, Md.

18. Funeral director..... WM. J. TICKNER & SONS  
Address..... Balto., Md.19. 4-18 46  
(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md.      County.....

City or town..... Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No..... 2401 Garrison Blvd.  
(If rural, give LOCATION)

2.(a) If veteran, name war.

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... April 17, 1946, at 7:00 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Apr. 14, 1946, to Apr. 17, 1946

and that I last saw h..... alive on Apr. 17, 1946

Immediate cause of death.....

Cerebral Hemorrhage      DURATION 5 days

Due to..... Cerebral Arterio Lesions

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) (County) (State)

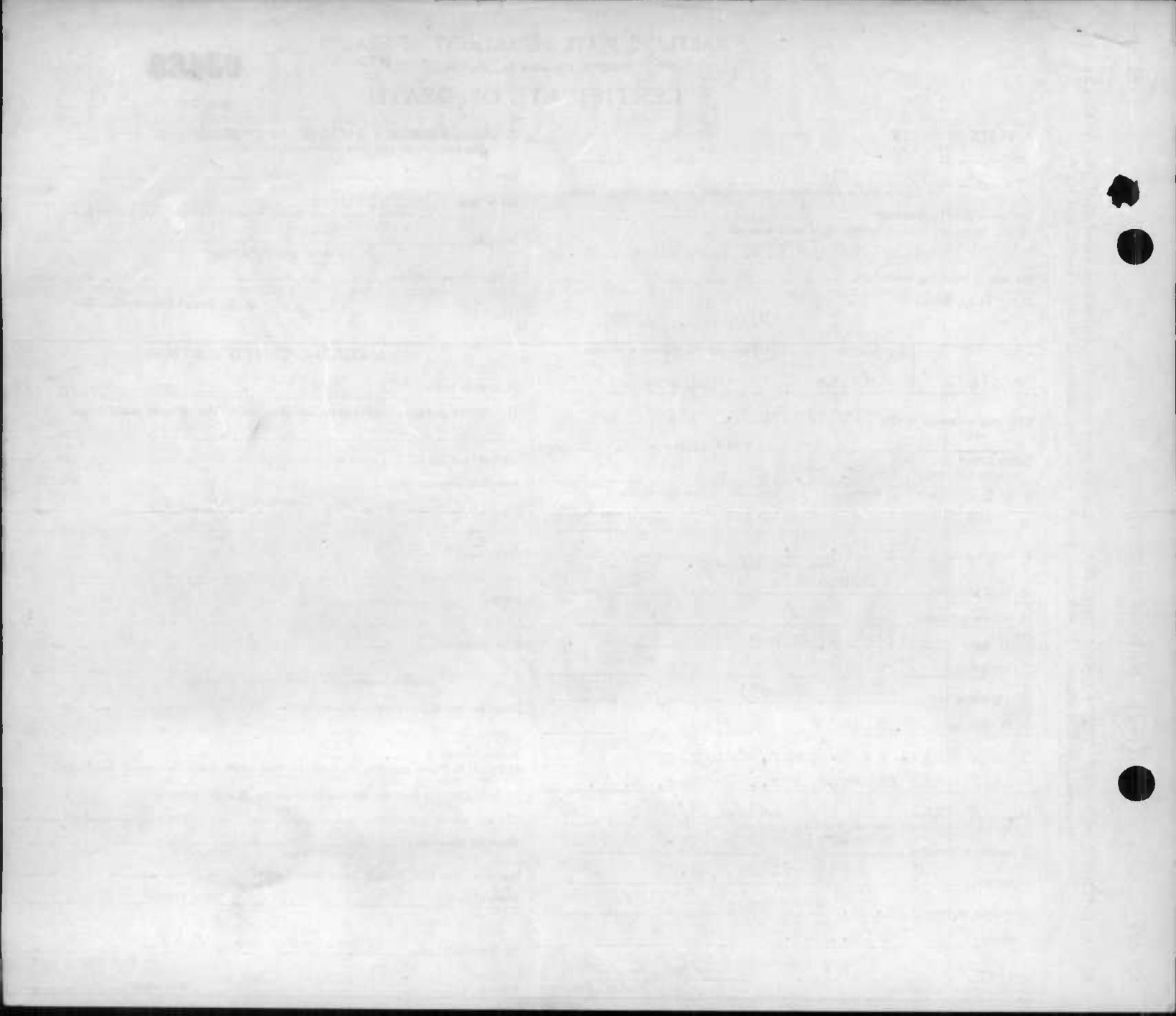
Injured at home, farm, industry, public place (where?)

Means of Injury..... Injured at work?

23. SIGNATURE.....

M. D. or other.....

Address..... Date signed.....



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

63461

Reg. Diat. No. 42

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH:

County.....

Baltimore  
Arbutus

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

20 years

Hospital, Institution, or street address where death occurred:.....

4210 Leeds Avenue

How long in hospital or institution?.....

## 3. (a) FULL NAME

Alice T. Barbour

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

March 12, 1862

(b) If alive, give age..... years

8. AGE:

Years      Months      Days      If less than one day

84      1      10      hrs.      min.

9. Birthplace

Middleton, Frederick County, Md.

(Town, county, and state)

10. Usual occupation.....

Housework

11. Industry or business.....

Charles B. Barbour, Sr.

12. Name.....

Maryland

13. Birthplace

Annie E. Riddlenoser

14. Maiden name.....

Maryland

15. Birthplace

Grace Bradley

16. Informant.....

15-16 E. 16th Street South

Birmingham, Alabama

17. Burial

Date thereof..... April 24, 1906

(Burial, cremation, or removal, Which?)

(month) (day) (year)

Cemetery or crematory.....

London Park

Location.....

Baltimore, Maryland

18. Funeral director.....

George L. Schwab

Address.....

2101 Frederick Avenue

19. Date rec'd by registrar.....

April 23, 1906

(Date rec'd by registrar)

Registrar.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Maryland

County.....

Baltimore

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4210

Leeds Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war.....

None

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... April 22, 1906, at 10:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov 1, 1905, to April 22, 1906,

and that I last saw her alive on April 22, 1906.

Immediate cause of death.....

DURATION

apoplexy

Due to.....

cardiac muscular disease?

1 day

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

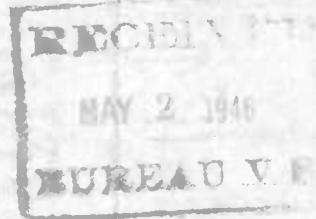
Means of injury..... Injured at work?

23. SIGNATURE.....

M. D. or other

Address..... 3410 Brush Street

Date signed..... April 23, 1906



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46-2

## CERTIFICATE OF DEATH

63462

38

Reg. Dist. No.

## 1. PLACE OF DEATH:

County.....

Baltimore

City or town.....

Towson

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

16 E Chesapeake Ave.

How long in hospital or institution?

## 3. (a) FULL NAME

Roy Francis Barwick

4. Sex

5. Color of Face

6.(a) Single, married, widowed, or divorced

Male

White

Married

6.(b) Name of husband or wife.....

Pearl Delta Barwick

7. Birth date of deceased (mo., day, yr.)

March 3, 1898

6.(c) If alive, give age... 51 years

8. AGE:

Years

Months

Days

If less than one day

58

1

17

hrs.

min.

9. Birthplace

Hamilton, Ontario, Canada

(Town, county, and state)

10. Usual occupation

Carpenter

Self

11. Industry or business

MOTHER FATHER

William Robert Barwick

13. Birthplace

England

14. Maiden name

Harriett Elizabeth Murray

15. Birthplace

Canada

16. Informant

Mrs. Pearl D. Barwick

Address

16 E. Chesa. Ave., Towson, Md.

17. BURIAL

Date thereof April 22, 1946

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Prospect Hill Cemetery

Location

Towson, Md.

18. Funeral director

John Burke Sons

Address

Towson, Md.

19. (Date rec'd by registrar)

April 22, 1946

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Maryland County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

16 E. Chesapeake Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

220-05-1643

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 20, 1946 at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 3 1946 to April 18, 1946

and that I last saw him alive on April 18, 1946

Immediate cause of death

Carcinoma -  
Esophagus

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations  
(Inoperable) Date of op. April 1946

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of Injury

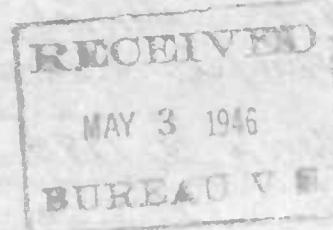
Injured at work?

23. SIGNATURE

John Burke, M.D. M. D. or other

Address

Towson, Md. Date signed April 22, 1946



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

03463

Reg. Dist. No.

X 38

## 1. PLACE OF DEATH:

County..... Baltimore

City or town..... Towson 4, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since Dec 11, 1944

Hospital, Institution, or street address where death occurred: Edowood Sanatorium, Towson 4, Md.

How long in hospital or institution? Since Dec 11, 1944

## 3. (a) FULL NAME

Charles Jacob Beublitz

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male White married

6. (b) Name of husband or wife..... Anna Beublitz

7. Birth date of deceased (mo., day, yr.)

Sept 11, 1874

6. (c) If alive, give age 67 yrs

years

8. AGE:

Years 71 Months 7 Days 00

It less than one day

hrs.

min.

9. Birthplace.....

Baltimore County, Md

(Town, county, and state)

10. Usual occupation..... Painter

11. Industry or business

12. Name..... John Beublitz

13. Birthplace..... Md

14. Maiden name..... Mary Martin

15. Birthplace..... Md

## Personal History- Hospital Records

16. Informant.....

Address..... Edowood Sanatorium, Towson 4, Md

17. Burial (Burial, cremation, or removal, which?)

Date thereof..... April 20 - 1945

(month) (day) (year)

Cemetery or crematory..... Fork M. E. Cemetery

Location..... Fork Md.

18. Funeral director..... Clarence E. Arthur

Address..... Fork Md.

19. Date rec'd by registrar..... April 19, 1946

Date rec'd by registrar..... April 19, 1946

G. M. Bacon

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Baltimore

City or town..... Edowood 40 (If outside city or town limits, write RURAL and give nearest town)

Street No..... Middleborough (If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

214-16-9986

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... April 18 1946 at 4:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 11, 1944 to April 18, 1946 and that I last saw him alive on April 18, 1946.

Immediate cause of death.....

Pulmonary tuberculosis

Due to.....

DURATION

Onset about April 18, 1946

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

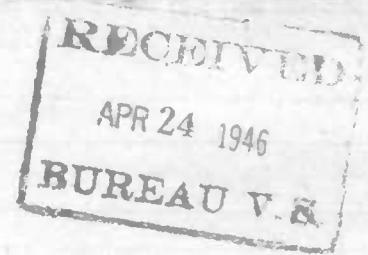
Means of injury.....

Injured at work?

23. SIGNATURE..... W.C. Bridges

M. D. or other

Address..... Tows on 4, Maryland Date signed..... April 18-46



Evidence for change of age of deceased is shown on MARYLAND STATE DEPARTMENT OF HEALTH  
2411 N. Charles St., Baltimore 3

63464

FILM No. 104 MAY 16 1946

Reg. Dist. No. 40

CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County.....

City or town.....

Baltimore Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Samuel T. Beares

3. (b) Social Security Number

4. Sex

M. 5. Color or race

W. Married

6.(a) Single, married, widowed, or divorced

6.(b) Name of husband as wife

Elizabeth Beares

7. Birth date of

deceased (mo. day, yr.)

Aug 4 - 1878

6.(c) If alive, give age years

8. AGE:

Years	Months	Days	If less than one day
67	68	8	hrs. min.

9. Birthplace.....

(Town, county, and state)

Baltimore Md.

10. Usual occupation.....

Farmer

11. Industry or business

Geo. T. Beares

12. Name.....

Geo. T. Beares

13. Birthplace.....

14. Maiden name.....

Elizabeth Blakeley

15. Birthplace.....

Tilton Beares

16. Informant.....

Burial

17. (Burial, cremation, or removal. Which?) Cemetery or crematory

Date thereof.....

(month) (day) (year)

Location.....

Baltimore Md.

18. Funeral director.....

Address.....

Clarence E. Arthur

19. April 9 1946

(Date rec'd by registrar)

c. e. Arthur

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

City or town.....

Baltimore

County.....

Baltimore

Street No.....

1012

(If outside city or town limits, write RURAL and give nearest town)

2.(a) If veteran, name war.....

(If rural, give LOCATION)

(If rural, give LOCATION)

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

April 7 1946 3 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 6 1946 to April 7 1946 and that I last saw him alive on April 7, 1946.

Immediate cause of death

Coronary Thrombosis DURATION 36 hrs.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE

Gifford F. Hudson, M.D. M. D. or other

Address..... Date signed 4/9/46

RECEIVED

APR 15 1946

BUREAU V.E.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

63465

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

County ..... Baltimore  
 City or town ..... Leatonsville Md.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? ..... 7 yrs.  
 Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Walter Shotwell Bellis, Sr.

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

<u>Male</u>	<u>White</u>	<u>Widower</u>
-------------	--------------	----------------

6. (b) Name of husband or wife ..... Gertrude Estelle Harkins7. Birth date of deceased (mo., day, yr.) ..... June 16, 1865  
 6. (c) If alive, give age ..... years

8. AGE: Years	Months	Days	If less than one day
80	10	8	hrs. min.

8. Birthplace ..... Hackettstown NJ  
(Town, county, and state)10. Usual occupation ..... Pharmacist retired

## 11. Industry or business

12. Name ..... Jacob P. Bellis13. Birthplace ..... New Jersey14. Maiden name ..... Mary Louise Shotwell15. Birthplace ..... New Jersey16. Informant ..... Walter S. Bellis, Jr.Address ..... 23 Bloomsbury Ave - Leatonsville17. Burial ..... Burial  
(Burial, cremation, or removal. Which?)Date thereof ..... Apr. 27, 1946  
(month) (day) (year)Cemetery or crematory ..... Woodlawn CemeteryLocation ..... Woodlawn Md18. Funeral director ..... Easton SonsAddress ..... 608 Frederick Ave.19. ..... 4-26-1946  
(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State ..... Maryland County ..... BaltimoreCity or town ..... Leatonsville  
(If outside city or town limits, write RURAL and give nearest town)Street No. ..... 14 Sanford Ave.  
(If Rural, give LOCATION)2.(a) If veteran, name war ..... Spanish American War

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH ..... April - 24 - 1946 at 7:29 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 1 24 1936 to 4-24-1946 and that I last saw him alive on 4-23 1946

## Immediate cause of death

Myocardial Degeneration DURATION 10 yrs.

## Due to

## Due to

## Other conditions

(Include pregnancy within 8 months of death)

## Major findings of operation

Date of op.

## Autopsy results

No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

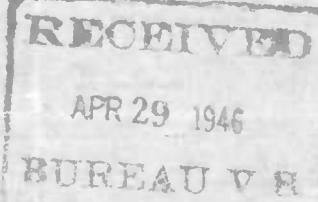
Date of

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE ..... S. Lloyd Johnson M. D. or otherAddress ..... Catonsville Md Date signed 4-25-46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 518

PC  
C3467

## CERTIFICATE OF DEATH

Reg. Dist. No. 42

## 1. PLACE OF DEATH:

County..... **Baltimore**City or town..... **Relay**, 27, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... **3-23-46**

Hospital, institution, or street address where death occurred:

..... **Relay Sanitarium**How long in hospital or institution?..... **3-23-46**

## 3. (a) FULL NAME

**Bode, William Conrad, M.D.**4. Sex..... **Male** 5. Color or race..... **White** 6. (a) Single, married, widowed, or divorced..... **Married**6. (b) Name of husband or wife..... **Gulielma H. Bode**7. Birth date of deceased (mo., day, yr.)..... **Mar 26, 1869** 6. (c) If alive, give age..... years8. AGE: Years..... **77** Months..... Days..... **13** If less than one day..... hrs..... min.....9. Birthplace..... **Germany** (Town, county, and state)10. Usual occupation..... **Physician**

## 11. Industry or business

12. Name..... **William, H. Bode**13. Birthplace..... **Germany**14. Maiden name..... **Dorothy Crendel**15. Birthplace..... **Germany**16. Informant..... **Wife - Mrs. Gulielma H. Bode**Address..... **1900 Maryland avenue, Baltimore, 18, Md.**17. **Burial**

(Burial, cremation, or removal. Which?)

Date thereof..... **4/23/46**  
(month) (day) (year)Cemetery or crematory..... **St. James Cemetery, Baltimore, Md.**Location..... **Lady's Manor Bldg. to meet**18. Funeral director..... **Gulier & Mitchell**Address..... **1900 Eastern Place -**19. **4-8 1946**  
(Date rec'd by registrar)Anselm  
Adk

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... **Md.** County.....City or town..... **Baltimore City**  
(If outside city or town limits, write RURAL and give nearest town)Street No..... **1900 Maryland Avenue** Baltimore, 18, Md.  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... **April 7, 1946** at **5:15 AM**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

**March 23, 1946**, to **April 7, 1946**,and that I last saw him alive on **April 6, 1946**.

Immediate cause of death.....

**Congestive heart failure**Due to..... **Carries of prostate with**Due to..... **Extensive tubercles**

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE..... **Lewis P. Gandy, M.D.** M. D. or otherAddress..... **Relay 22nd** Date signed..... **4/7/46**

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

03467 P

## CERTIFICATE OF DEATH

Reg. Dist. No. 3D

## 1. PLACE OF DEATH:

County Baltimore

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Grand Convent Home

How long in hospital or institution?

## 3. (a) FULL NAME

Maud Bolton (Bolton)

## 3. (b) Social Security Number

215-03-1972

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

White

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

March 24, 1880

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal, which?)

Cemetery or crematory

Location

18. Funeral director

Address

19. (Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

814 8 North Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Apr 2 1946 at 10:45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 19, 1946, to April 19, 1946, and that I last saw her alive on April 1st, 1946.

Immediate cause of death

Cerebral hemorrhage

Due to arteriosclerosis

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE H. W. SCHEYER, M. D.

3921 EDMONDSON AVE.

M. D. or other

Address BALTIMORE 20, MD Date signed 4/3/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131-20

## CERTIFICATE OF DEATH

C3468

Reg. Dist. No. 4X

## 1. PLACE OF DEATH:

County..... Baltimore

City or town..... Fort Howard

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 58 Days

Hospital, institution, or street address where death occurred:

Vets. Adm. Hosp., Ft. Howard, Maryland

How long in hospital or institution?..... 58 Days

## 3. (a) FULL NAME

HARRY H. BOND

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Married

6.(b) Name of husband or wife..... Mamie Bond

6.(c) If alive, give age..... 47 years

7. Birth date of deceased (mo. day. yr.)..... 5-5-94

8. AGE:	Years	Months	Days	If less than one day
	51	11	15	hrs. min.

9. Birthplace..... Maryland  
(Town, county, and state)

10. Usual occupation..... Chauffeur

## 11. Industry or business

12. Name..... Charles Bond

13. Birthplace..... Virginia

14. Maiden name..... Katy Stakma

15. Birthplace..... Maryland

16. Informant..... Clinical Records, Vets. Adm. Hosp.

Address..... Ft. Howard, Maryland

17. Burial..... Date thereof..... 4/23/46  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory..... Baltimore National Cemetery  
Location..... Baltimore, Md.

18. Funeral director..... Charles R. Law

Address..... 802 Madison Ave, Balto., Md.

19. Date of death..... 4/22/46  
(registrar)..... A. W. Hedrick  
Registrar..... D.M.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland..... County.....

City or town..... Baltimore.....  
(If outside city or town limits, write RURAL and give nearest town)

Street No..... 1444 Morton Street.....

(If rural, give LOCATION)

2.(a) If veteran, name war..... WW-I

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... April 20, 1946, at 5:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 21, 1946, to April 20, 1946, and that I last saw him alive on April 20, 1946.

Immediate cause of death.....

Disease of the Heart..... (2-21-46)

Mitral Stenosis, Mitral Insufficiency, plus)

x Aortic Insufficiency, Cardiac enlargement, myocardial insufficiency

x

Other conditions..... Chronic nephritis and Hypertension  
(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE..... Robert M. Cullison  
R.M. CULLISON, M.D. ACT. CLIN. DIR.  
Ft. Howard, Md.

Address..... Date signed..... 4-20-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 10

03469

Reg. Dist. No. 40

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH:

County..... Baltimore

City or town..... Whittemarsh

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... life

Hospital, Institution, or street address where death occurred:

Philadelphia Road

How long in hospital or institution?

## 3. (a) FULL NAME

EVELYN J. BOWERS

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

female

white

single

6. (b) Name of husband or wife.....

6. (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.)

December 24th, 1945

8. AGE:

Years

Months

Days

If less than one day

3

27

hrs.

min.

9. Birthplace..... Balto., Md.

(Town, county, and state)

10. Usual occupation.....

11. Industry or business

12. Name..... J. Louis Bowers

13. Birthplace..... Balto. Co., Md.

14. Maiden name..... Evelyn M. Greaver

15. Birthplace..... Balto., Md.

16. Informant..... Mr. Louis Bowers

Address..... Philadelphia Rd., Whittemarsh, Md.

17. Burial..... April 23, 1946

(Burial, cremation, or removal. Which?) Date thereof..... (month) (day) (year)

Cemetery or crematory..... Parkwood

Location..... Balto., Md.

18. Funeral director..... Lazarus Funeral Home

Address..... 7401 Belair Road

19. (Date rec'd by registrar)..... 4/27/46

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md. County..... Balto.

City or town..... Whittemarsh

(If outside city or town limits, write RURAL and give nearest town)

Street No..... Philadelphia Road

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

\*\*\*

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... April 20th 1946, at 9 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

4/18/46 to 4/20/46, and that I last saw her alive on 4/20/46.

Immediate cause of death.....

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

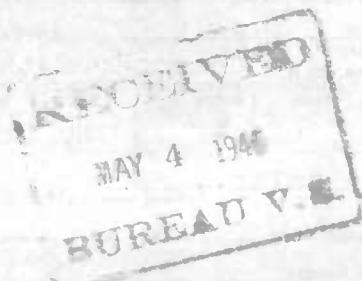
Means of injury.....

Injured at work?

23. SIGNATURE.....

Address..... 3523 E. Baltimore St. M. D. or other.....

Date signed..... 4/27/46



X  
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 470

63470

## CERTIFICATE OF DEATH

Reg. Dist. No. 38

**1. PLACE OF DEATH:**  
County..... BALTIMORE

City or town..... TOWSON  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 2 years, 4 months.

Hospital, institution, or street address where death occurred:

Sheppard and Enoch Pratt Hospital, Towson.

How long in hospital or institution?..... 1 month, 17 days Md.

**3. (a) FULL NAME**  
reston  
EDWARD P. BROWN

4. Sex	5. Color or race	B.(a) Single, married, widowed, or divorced
Male	White	Married

6. (b) Name of husband or wife..... Irene Wilcox Brown

7. Birth date of deceased (mo., day, yr.)..... July 21, 1870

8. AGE: Years Months Days If less than one day  
75 9 2 .brs. ? min.

9. Birthplace..... Bridgewater, Albemarle Co., Va.  
(Town, county, and state)

10. Usual occupation..... Pharmacist

11. Industry or business..... Sheppard-Pratt Hospital

FATHER 12. Name..... Dr. Thomas Heskitt Brown

MOTHER 13. Birthplace..... Rockingham Co., Virginia

14. Maiden name..... Elizabeth Carpenter

15. Birthplace..... Mt. Crawford, Va

16. Informant..... Mrs. E. P. Brown

Address..... 417 Hillside Ave, Daytona Beach

17. Burial (burial, cremation, or removal. When?)..... April 25, 1946

Cemetery or crematory..... St. John's Episcopal Cem.

Location..... Kingsville, Baltimore Co., Md.

18. Funeral director..... John Brown Sons

Address..... Towson, Md.

19. April 24, 1946 (Date rec'd by registrar)

**2. USUAL RESIDENCE (HOME) OF DECEASED:**  
(For newborn infants give residence of mother)

State..... Maryland County..... Baltimore

City or town..... Towson  
(If outside city or town limits, write RURAL and give nearest town)

Street No..... Sheppard and Enoch Pratt Hospital

(If rural, give LOCATION)

2. (a) If veteran, name war..... none

**3. (b) Social Security Number**

none

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... April 23 1946 at 12:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 6 1946 to April 23 1946

and that I last saw him alive on April 23 1946

Immediate cause of death..... Bronchopneumonia

Secondary to constriction of right bronchi

Due to..... Primary carcinoma of right bronchi with metastases

to liver, adrenals, and kidneys

Other conditions..... Generalised arteriosclerosis Old coronary infarct

(Include pregnancy within 8 months of death) 3 yrs.

DURATION..... 1 week unknown

Major findings of operations..... Date of op.

Autopsy results..... Confirmation of above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

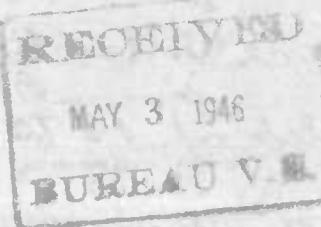
23. SIGNATURE..... McElgin, M.D.

M. D. or other

THE SHEPPARD & ENOCH PRATT HOSPITAL

Address..... Date signed Apr. 23, 1946

TOWSON 4, MD.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 163-B

## CERTIFICATE OF DEATH

03471 38  
Reg. Dist. No.

## 1. PLACE OF DEATH:

County.....  
City or town..... Parkville Baltimore 14  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 7 years  
Hospital, institution, or street address where death occurred:..... Home

How long in hospital or institution?

## 3. (a) FULL NAME

Thelma Elizabeth Brown

## 4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

F

W

Married

Patent Wm Brown

## 6. (b) Name of husband or wife.....

## 7. Birth date of deceased (mo., day, yr.)

January 1-1914

6. (c) If alive, give age 38 years

If less than one day

hrs. min.

32

Years Months Days

Due to..... Melancholia

Birthplace..... Baltw Md.

(Town, county, and state)

at home

10. Usual occupation.....

## 11. Industry or business

12. Name..... S. Scally

13. Birthplace..... New

14. Maiden name..... Dorothy E. Hasker

15. Birthplace..... New

16. Informant..... Edan Wm Brown

Address..... 7804 Belmont e

17. Burial..... Date thereof..... 5-4-46

(Burial, cremation, or removal. Which?) Cemetery or crematory..... Parkwood

Location..... Baltw Md

18. Funeral director..... Leonard Blum

Address..... 5305 Warfield Rd

19. 4/30 45 Death record

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md. County..... Baltw

City or town..... Parkville

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 7804 Belmont Ave

(If rural, give LOCATION)

## 2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... April 29, 1946, at 6 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

None 19... to 19...

and that I last saw h..... alive on .....

Immediate cause of death..... Carbon monoxide

poisoning - Suicide

Due to..... Melancholia

Duration..... 4/29/46

1946

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide or homicide..... Suicide Date of..... 4/29/46

Where did injury occur?..... Parkville (City or town) Baltw (County) Md. (State)

Injured at home, farm, industry, public place (where?)..... Home

Means of injury.....

Injured at work?.....

23. SIGNATURE..... Rollin L. Hudson M.D. D.M.E.

M. D. or other.....

Address..... Towson 4 Md. Date signed..... 4/29/46

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46-1

## CERTIFICATE OF DEATH

0347232  
Reg. Dist. No. 2

1. PLACE OF DEATH: Baltimore  
 County \_\_\_\_\_  
 City or town Stevenson (If outside city or town limits, write RURAL NEAR and give town)  
 Street address, hospital, or institution: Hillside Road  
 Stay in hospital or Inst. (yrs., or mos., or days) \_\_\_\_\_  
 Stay in this community (yrs., or mos., or days) \_\_\_\_\_

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State Maryland County Baltimore  
 City or town Stevenson Ward No. \_\_\_\_\_  
 (If outside city or town limits, write RURAL NEAR and give town)  
 Street No. Hillside Road (If rural give LOCATION)  
 2(a) IF VETERAN, NAME WAR \_\_\_\_\_

## 3. (a) FULL NAME

Elmer Fishbaugh Burnham

## 3. (b) Social Security Number \_\_\_\_\_

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married  
 6 (b) Name of husband or wife Pearl Marcella Burnham  
 6(c) If alive, give age 52 years  
 7. Birth date of deceased (mo., day, yr.) February 27 1890  
 8. AGE: Years 56 Months 1 Days 15 If less than one day — hrs. — min.  
 9. Birthplace Chestnut Ridge, Balto. Co., Md. (Town, county, and state)  
 10. Usual occupation Farmer  
 11. Industry or business Tenant Farmer  
 12. Name Elijah Burnham  
 13. Birthplace Maryland  
 14. Maiden name Mary Lee  
 15. Birthplace Maryland  
 16. Informant Mrs. Pearl M. Burnham  
 Address Hillside Road, Stevenson, Md.  
 17. Burial Date thereof April 16, 1946 (month) (day) (year)  
 (Burial, cremation, or removal. Which?) Cemetery or crematory Carroll's Cemetery  
 Location Chestnut Ridge, Balto. Co., Md.  
 18. Funeral director John Burns' Sons  
 Address Towson, Maryland  
 19. (Date rec'd by registrar) Apr 17 1946 Registrar John E. Nichols  
 (Date rec'd by registrar) 19 \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH 4/14/46 — 19 — at 9 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-14-46 — 19 — to 4-13-46 — 19 — and that I last saw him alive on 4-13-46 — 19 —Immediate cause of death Carcinoma of the liver DURATION 1 1/2 yrs

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Gastritis

(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_

Of operations: \_\_\_\_\_

Of autopsy: \_\_\_\_\_

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_

Injured at work? \_\_\_\_\_

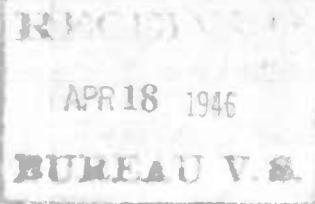
23. SIGNATURE Emile L. Saffell

M. D. or other \_\_\_\_\_

Address RestonDate signed 4/14/46

## PHYSICIAN

Please underline the cause to which death should be charged statistically.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

03473

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County..... **Baltimore**City or town..... **Catonsville**

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

## 3. (a) FULL NAME

**ANNABELL CAIRNCROSS**

## 4. Sex

Female

## 5. Color or race

White

## 6.(a) Single, married, widowed, or divorced

Widowed

6.(c) Name of husband or wife..... **William W. Cairncross**

## 7. Birth date of deceased (mo., day, yr.)

May 23, 1866

6.(c) If alive, give age D. years

## 8. AGE:

Years  
79Months  
10Days  
15

If less than one day

hrs. min.

## 9. Birthplace.....

**Howard County Maryland**  
(Town, county, and state)

## 10. Usual occupation.....

Housewife

## 11. Industry or business

At Home

## FATHER

## 12. Name.....

Maryland

## 13. Birthplace

Annabell Hobbs

## MOTHER

## 14. Maiden name.....

Maryland

## 15. Birthplace

Mrs. May Meyer

## 16. Informant.....

451 Yale Ave.

## Address

## BURIAL

## (Burial, cremation, or removal. Which?)

Date thereof..... **APRIL 10/46**

(month) (day) (year)

## Cemetery or crematory.....

WOODLAWN CEMETERY

## Location.....

WOODLAWN MARYLAND

## 18. Funeral Director.....

## Address

1300 EUTAW PLACE.....

## 19.

4-10 1946

(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... **Maryland** County.....City or town..... **Baltimore**

(If outside city or town limits, write RURAL and give nearest town)

Street No. **451 Yale Ave.**

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

April 7th.

46 3: P.M.

19..... at..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

31 6 1946 to 4 1 1946

and that I last saw her alive on 4 1 1946

## Immediate cause of death.....

**Acute Cardiac Failure** 1da

## Due to.....

**Generalized Arteriosclerosis**Due to..... **Cardiovascular Disease**

## Other conditions.....

**Senility** 5yr

(Include pregnancy within 8 months of death)

## Major findings or operations.....

Date of op.

## Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur? .....

(City or town)

(County) (State)

Injured at home, farm, industry, public place (where?) .....

## Means of injury.....

Injured at work?

## 23. SIGNATURE.....

M. D. or other

Washington Blvd. 419146

Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

B2

03474

## CERTIFICATE OF DEATH

Reg. Dist. No. 38

## 1. PLACE OF DEATH:

County

Baltimore

City or town

Stonleigh

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Armenia Friends Home

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

Feb 4 1886

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

(Town, county, and state)

10. Usual occupation.

11. Industry or business

FATHER

12. Name

William Johnson

MOTHER

13. Birthplace

Mattie J Biggell

14. Maiden name

15. Birthplace

16. Informant

Address

17. (Burial, cremation, or removal) Which?

Date thereof (month) (day) (year)

Cemetery or crematory

Oakwood

Location

Fairfax

18. Funeral director

Address

William Johnson

19. (Date rec'd by registrar)

4-9-46 Accepted

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Baltimore

County

City or town

Stonleigh

Street No.

812 Madison Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

Apr 8 1946 at 89 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 28 1946 to April 8 1946

and that I last saw her alive on April 7 1946 1946

Immediate cause of death

Cerebral Hemorrhage

DURATION

10 days

Due to

Hypertensive Cardio-  
Vascular Disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

No

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

## 23. SIGNATURE

John F Schaefer M. D. or other

Address 903 Haxford Rd Date signed 4/8/46

## HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH

Mt. Washington

CITY OF BALTIMORE: (No. 1701 SUGGRAVE St., Ward)

(13475) Registered No. 38

Length of residence in city or town where death occurred 68 yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME LAWRENCE Sangston CLARKE

If U.S. Veteran  
specify WAR

(a) Residence: No. 1701 SUGGRAVE St., Ward.

MD.

(Usual place of abode)

(If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)		
Male	White	Married		
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of LAURA GRAFFLIN CLARKE				
6. DATE OF BIRTH (month, day, year)				
7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
68		5	20	
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.			
	SALESMAN.			
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.			
	PAPER Co.			
	10. Date deceased last worked at this occupation (month and year)			
	FEB 13 1946			
	11. Total time (years) spent in this occupation 42			
12. BIRTHPLACE (city or town) (State or country)				
BALTIMORE MD.				
FATHER	13. NAME HENRY E. GARRE			
MOTHER	14. BIRTHPLACE (city or town) (State or country)			
	Baltimore MD			
	15. MAIDEN NAME Mary Sangston			
	16. BIRTHPLACE (city or town) (State or country)			
	Colony Co. Md			
	17. INFORMANT Laura Grafflin Clarke			
	(Address) 1701 Suggrave Ave			
	18. BURIAL, CREMATION, OR REMOVAL			
	Buried Ridge Cemetery Balt. Date 4/12/1946			
	Place			
	19. UNDERTAKER John O. Mitchell Sons			
	(Address) 1900 Estate Place			
	20. FILED 4/12 1946 D. W. Nedrick			
	Registrar			

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) April 11<sup>th</sup> 1946  
 22. I HEREBY CERTIFY, That I attended deceased from January, 1946 until April 9, 1946  
 last saw him alive on April 9, 1946. Death is said to have occurred on the date stated above, at 5:30 P.M.

The principal cause of death and related causes of importance were as follows:

Pneumonia Heart Disease (3)  
 Mitral Stenosis (3)  
 Cerebral Hemorrhage (2)

Other contributory causes of importance:

Pulmonary edema (3)  
 30 day

Was an operation performed? No Date of

For what disease or injury?

What test confirmed diagnosis? — Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:  
 Accident, suicide, or homicide? — Date of injury, 19

Where did injury occur? — (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place

Manner of injury —

Nature of injury —

24. Was disease or injury in any way related to occupation of deceased?

No If so, specify

(Signed) *John O. Mitchell Sons* M. D.  
 (Address) *Baltimore, Md.*

S. S. N. 213-03-6707

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *90d*

## CERTIFICATE OF DEATH

03476

Reg. Dist. No. 31

## 1. PLACE OF DEATH:

County *Baltimore*  
City or town *Mariottsville*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *37 years*  
Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

*Dora Verina Claus*4. Sex *f.* 5. Color or race *W* 6. (a) Single, married, widowed, or divorced *Married*6. (b) Name of husband or wife *Louis Claus*6. (c) If alive, give age *84* years7. Birth date of deceased (mo., day, yr.) *January 22, 1863*8. AGE: Years *83* Months *3* Days *6* If less than one day  
hrs.  min. 9. Birthplace *Md.*  
(Town, county, and state)10. Usual occupation *Housewife*11. Industry or business *Our Home*12. Name *Henry Taylor*13. Birthplace *Germany*14. Maiden name *Alma Grace*15. Birthplace *Germany*16. Informant *Mr. Louis Claus*Address *Mariottsville, Md.*17. Burial Date thereof *May 1, 1946*  
(Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)Cemetery or crematory *Wards Chapel Cem.*Location *Liberty Road Hollands, Md.*18. Funeral director *C. Harry Clark*Address *Sykesville, Md.*19. *4/25/46* 1946 *Tom E. Martin*  
(Date rec'd by registrar) Date signed *4/25/46*

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Md.* County *Baltimore*City or town *Mariottsville*  
(If outside city or town limits, write RURAL and give nearest town)Street No.   
(If rural, give LOCATION)2.(a) If veteran, name war 

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH *April 28 1946 at 6 P.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1942 to April 27, 1946

and that I last saw her alive on April 27, 1946

Immediate cause of death

*Cardio Vasculat Disease*

DURATION

Due to Due to Other conditions 

(Include pregnancy within 3 months of death)

Major findings of operations Date of op. Autopsy results 

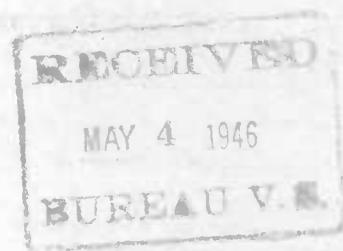
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide  Date of Where did injury occur?  (City or town)  (County)  (State)Injured at home, farm, industry, public place (where?) Means of injury  Injured at work? 23. SIGNATURE *Tom E. Martin*

M. D. or other

Address *Randallstown* Date signed *4/25/46*



I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *Balt.*

## CERTIFICATE OF DEATH

03477

Reg. Dist. No. *32*

<b>1. PLACE OF DEATH:</b> County ..... <i>Balto.</i>		
City or town ..... <i>Owings Mills</i> (If outside city or town limits, write RURAL and give nearest town)		
How long in above place of death?		
Hospital, Institution, or street address where death occurred:		
How long in hospital or institution?		

**2. USUAL RESIDENCE (HOME) OF DECEASED:**  
(For newborn infants give residence of mother)

State ..... <i>Md.</i>	County ..... <i>Balto.</i>
City or town ..... <i>Owings Mills</i> (If outside city or town limits, write RURAL and give nearest town)	
Street No. .... (If rural, give LOCATION)	

2.(a) If veteran, name war.....

**3. (a) FULL NAME**

JAMES L. CONSTANTINE

**3. (b) Social Security Number**

212-26-4920

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced	
Male	White	Married	
6.(b) Name of husband or wife ..... <i>Bertha Constantine</i>			
7. Birth date of deceased (mo., day, yr.)	6.(c) If alive, give age ..... years		
March 30, 1870			
8. AGE: Years	Months	Days	If less than one day
76	0	5	.... hrs. .... min.
9. Birthplace ..... <i>Reisterstown, Md.</i> (Town, county, and state)			
10. Usual occupation ..... <i>Night Watchman</i>			
11. Industry or business ..... <i>Park &amp; Tillford</i>			
12. Name ..... <i>Wm. Constantine</i>			
13. Birthplace ..... <i>Balto. Co., Md.</i>			
14. Maiden name ..... <i>Unknown</i>			
15. Birthplace			
16. Informant ..... <i>Mr. W. Elmer Constantine</i>			
Address ..... <i>5265 Nelson Ave. 15</i>			

17. Burial (Burial, cremation, or removal. Which?)	Date thereof..... <i>4/8/46</i> (month) (day) (year)
Cemetery or crematory ..... <i>Woodlawn Cem.</i>	
Location ..... <i>Woodlawn, Md.</i>	
18. Funeral director ..... <i>WM. J. TICKNER &amp; SONS</i>	
Address ..... <i>Balto., Md.</i>	
19. Apr 6 - 1946 <i>E. E. Michaels</i> (Date rec'd by registrar)	

**MEDICAL CERTIFICATION**

20. DATE OF DEATH ..... April 5, 1946 at 6:00A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from *Funeral* *Jan 19*, to *April 5*, 1946, and that I last saw h. m. alive on *April 2*, 1946.

Immediate cause of death ..... <i>Coronary Thrombosis</i>	DURATION <i>dead</i>
Due to ..... <i>Chronic Myocarditis</i>	
Due to ..... <i>Atero Sclerotic</i>	
Other conditions ..... <i>Senility</i>	

(Include pregnancy within 3 months of death)

## Major findings or operations.

Date of op.

## Autopsy results.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

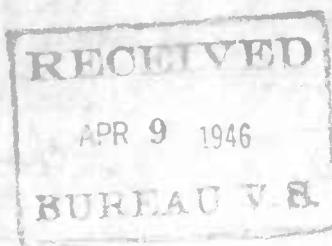
Injured at home, farm, industry, public place (where?)

## Means of Injury

Injured at work?

## 23. SIGNATURE

*E. E. Michaels, M.D.*  
M. D. or other  
Address ..... *Prescott 8, Md.* Date signed *4-6-46*



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03478

Reg. Dist. No.

## CERTIFICATE OF DEATH

42

## 1. PLACE OF DEATH:

County..... Balto.  
 City or town..... Lansdown  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:  
2111 Aletta Ave.

How long in hospital or institution?

## 3. (a) FULL NAME

Laura A. Crawford (Laura Strome Violette)

Crawford) 3. (b) Social Security Number  
217-16-5791

## 4. Sex

## 5. Color or race

## 6.(a) Single, married, widowed, or divorced

Female

White

D

## 6.(b) Name of husband or wife.....

## 6.(c) If alive, give age..... years

## 7. Birth date of deceased (mo., day, yr.)

Sept. 26, 1893

## 8. AGE:

Years  
52Months  
6Days  
25

It less than one day

hrs. .... min.

## 9. Birthplace.....

(Town, county, and state)  
Pa.

## 10. Usual occupation.....

none

## 11. Industry or business

FATHER 12. Name..... Michael Strome

13. Birthplace..... Pa.

MOTHER 14. Maiden name..... Unk.

15. Birthplace..... Pa.

## 16. Informant..... Mr. Frank Rosenthal

Address 3709 Gough St.

## 17. Burial

(Burial, cremation, or removal. Which?)

Date thereof..... Apr. 24/46

(month) (day) (year)

Cemetery or crematory.....

Oak Lawn Cem.

Location.....

Balto. Md.

## 18. Funeral director.....

Address 2024 Orleans St.

19. 4/24/46 (Date rec'd by registrar)

A.W. Hedrick  
Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md. County.....

City or town..... Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No..... 3709 Gough St.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

MEDICAL CERTIFICATION

20. DATE OF DEATH..... April 21, 1946..... 19..... at..... 10:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

4/11/46..... 19..... to..... 4/21..... 19.....

and that I last saw her..... alive on..... 4/21/46..... 19.....

Immediate cause of death.....

Carcinoma of bladder

DURATION

6 mos

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State)

Injured at home, farm, industry, public place (where?).....

Means of Injury.....

Injured at work?

23. SIGNATURE.....

Benjamin Miller

M. D. or other

Address..... 2024 Orleans St. Date signed..... 4/23/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

County..... Baltimore

City or town..... Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 18 years, 17 days

Hospital, Institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution?..... 18 years, 17 days

## 3. (a) FULL NAME

Samuel M. Crawford

## 3. (b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

male white single

6.(b) Name of husband or wife..... no

7. Birth date of deceased (mo., day, yr.) May 31, 1886

8. AGE: Years Months Days If less than one day  
59 10 1 hrs. min.9. Birthplace..... Baltimore, Md.  
(Town, county, and state)

10. Usual occupation..... general laborer

11. Industry or business..... laboring

12. Name..... George C. Crawford

13. Birthplace..... Baltimore, Md.

14. Maiden name..... Clara J. Marshall

15. Birthplace..... Baltimore, Md.

## 16. Informant..... Hospital Records

Address..... Catonsville 28, Md.

17. Burial Date thereof..... 4/5/46  
(Burial, cremation, or removal, which)  
Cemetery or crematory..... Green Mount

Location..... Balto. Md.

18. Funeral director..... William Cook Inc.

Address..... 1217 St. Paul St.

19. 4-3 46 Death certificate  
(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County.....

City or town..... Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 1112 Guilford Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... 4/1 1946 at 10A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

4/1 1946 to 4/1 1946

and that I last saw him alive on no date 1946

Immediate cause of death.....

Arteriosclerotic Cardio-  
Vascular Disease

Due to.....

Due to.....

Other conditions..... none

(Include pregnancy within 3 months of death)

Major findings of operations..... none

Date of op.....

Autopsy results..... none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of Injury.....

Injured at work?

23. SIGNATURE

DEPUTY MEDICAL EXAMINER OF BALTIMORE COUNTY

M. D. or other

Address..... Elliott City, Md. Date signed..... 4/1/46

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 947

C3480

9

**CERTIFICATE OF DEATH**

Reg. Diet. No

38

1. PLACE OF DEATH County..... City or town..... (If outside city or town limits, write RURAL and give nearest town)			2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State..... County..... City or town..... (If outside city or town limits, write RURAL and give nearest town)				
How long in above place of death? Hospital, institution, or street address where death occurred: Ridgley Road			Street No..... (If rural, give LOCATION)				
How long in hospital or institution?			2.(a) If veteran, name war.....				
3. (a) FULL NAME  John W. Cursey			3. (b) Social Security Number				
4. Sex Male		5. Color or race White	6.(a) Single, married, widowed, or divorced Married		MEDICAL CERTIFICATION		
6.(b) Name of husband or wife Mary L.			2D. DATE OF DEATH Apr. 14 1943			and that I last saw h. in alive on Apr. 14 1943	
7. Birth date of deceased (mo., day, yr.) March 6 1878			21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Oct. 21 1943 to Apr. 14 1943			19. DURATION years	
8. AGE: Years 68 Months 8 Days 8 If less than one day hrs. min.			Immediate cause of death Heart failure				
9. Birthplace Baltimore Co. MD (Town, county, and state)			Due to Pulmonary edema			hours	
10. Usual occupation Production Worker			Due to Coronary Arteritis			10/21/43	
11. Industry or business R.P.			Other conditions arteriosclerosis -			years	
12. Name Charles W. Cursey			(Include pregnancy within 8 months of death)				
13. Birthplace Sarah Pocock MD			Major findings of operations			Date of op.	
14. Maiden name Sarah Pocock			Autopsy results				
15. Birthplace Mary L. Cursey			PHYSICIAN: Please underline the cause to which death should be charged statistically.				
16. Informant Address Lutherville MD			22. VIOLENCE: If death was due to external causes, fill in the following:				
17. (Burial, cremation, or removal, Which?) Date thereof Funeral 4/14/43 (month) (day) (year)			Accident, suicide, or homicide			Date of	
Cemetery or crematory London Park			Where did injury occur? (City or town) (County) (State)				
Location Baltimore Co. MD			Injured at home, farm, industry, public place (where?)				
18. Funeral director William Cook Jr.			Means of Injury Injured at work?				
Address 1217 2d Court St			23. SIGNATURE Bennett A. Blain			M. D. or other	
19. (Date rec'd by registrar) 4/15 1946 R.W. Hedrick Registrar			Address Lutherville, MD			Date signed 4/16/46	

**PLEASE WRITE PLAINLY, WITH UNFADING INK.** Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 50

## CERTIFICATE OF DEATH

03481 30

Reg. Dist. No.

## 1. PLACE OF DEATH:

County... Baltimore  
 City or town... Catonsville Md  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widow

6.(b) Name of husband or wife Frances Deahl7. Birth date of deceased (mo. day, yr.) July 28-1868 8.(c) If alive, give age ..... years

8. AGE: Years 77 Months 8 Days 23 If less than one day  
 hrs. ..... min.

9. Birthplace Berryville Va.  
Town, County, and state)10. Usual occupation Cabinet Maker

11. Industry or business

12. Name William Deahl13. Birthplace Berryville Va.14. Maiden name Mrs. Deahl

15. Birthplace

16. Informant Mildred V. KruegerAddress 1010 Frederick Ave17. Burial Date thereof April 23-46  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Mount CarmelLocation Baltimore Md.18. Funeral director Ellsworth CremacostAddress 3911 Liberty Heights Ave.19. 4-23 1946 at 9:00 AM  
(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Catonsville Md

City or town Catonsville Md  
(If outside city or town limits, write RURAL and give nearest town)Street No. 1010 Frederick Ave:  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 20 1946, at 11:58 PM21. I CERTIFY that death occurred on the date above stated, that I attended deceased from Dec 20 1945 to April 20 1946and that I last saw him alive on April 18 1946Immediate cause of death General Cachexia DURATION 7 MonthDue to Carcinoma of Orbit 7 Years

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Eliot W. Johnson MD M. D. or otherAddress 3432 Frederick Ave Date signed

Call from Zell

on transcript  
one permit.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 742

03482

Reg. Dist. No.

30

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH:

Baltimore  
CatonsvilleCity or town.....  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 19 years, 11 months, 17 days

Hospital, institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 19 yrs., 11 mo.s., 17 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Maryland County.....  
State.....Baltimore City or town.....  
(If outside city or town limits, write RURAL and give nearest town)302 Vineyard Lane Street No.....  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3.(a) FULL NAME

Nellie Deane

## 3.(b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female White Divorced

6.(b) Name of husband or wife William Deane over

6.(c) If alive, give age Unknown years  
7. Birth date of deceased (mo., day, yr.) 1907?8. AGE: Years Months Days If less than one day  
39? unk. unk. .... hrs. .... min.9. Birthplace Maryland  
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Home

12. Name Jessie Reeves

13. Birthplace South Carolina

14. Maiden name Nellie Bowersox

15. Birthplace Maryland

16. Informant Hospital records, Spring Grove Hospital

Address Catonsville, 28, Md.

17. Burial Date thereof 4/24/46  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Forest Park

Location Baltimore, Md.

18. Funeral director M. D. or other

Address 1219 St Paul St.

19. 4-22 44  
(To be filled by registrar)44  
Registrars

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 21st, 1946 19 at 4:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 4, 1926 19, to April 21 19, 46

and that I last saw her alive on April 21st, 1946 19.

Immediate cause of death Acute myelogenous leukemia

DURATION 15 days

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....

Autopsy results..... None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE Henry C. Mead, M.D.

M. D. or other

Address Catonsville, 28 Date signed 4/21/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93D

03483

Reg. Dist. No.

31

## CERTIFICATE OF DEATH

1. PLACE OF DEATH:  
Balto.  
County.....

City or town.....  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, Institution, or street address where death occurred:  
Clifmar Rd.

How long in hospital or institution?.....

## 3. (a) FULL NAME

HANNAH EMMA DELAPLANE

4. Sex Female	5. Color or race White	6. (a) Single, married, widowed, or divorced Single
------------------	---------------------------	--

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)  
July 25, 1860

8. AGE: Years 85	Months 8	Days 9	If less than one day hrs. .... min.
---------------------	-------------	-----------	--

8. Birthplace.....  
(Town, county, and state)  
Baltimore, Md.

10. Usual occupation.....  
Housewife

11. Industry or business

FATHER 12. Name..... Joseph Edmund Delaplane	Md.
--	-----

MOTHER 13. Birthplace..... Md.	Catherine Hiteshew
--------------------------------------	--------------------

14. Maiden name..... Catherine Hiteshew	Carroll Co., Md.
--	------------------

15. Birthplace..... Carroll Co., Md.	
---	--

16. Informant..... Mrs. C. Elinor Dulin	
--	--

Address..... Randallstown, Md.	
-----------------------------------	--

Burial (Burial, cremation, or removal. Which?) Cemetery or crematory..... Balto., Md.	Date thereof..... (month) (day) (year) Loudon Park Cem.
--	---

Location..... Balto., Md.	
------------------------------	--

18. Funeral director..... WM. J. TICKNER & SONS	
--	--

Address..... Balto., Md.	
-----------------------------	--

19. Date rec'd by registrar..... 4/4/46	1946 Signature Wm. E. Martin Registrar
--	---

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State.....  
Md.

City or town.....  
Randallstown

Street No.....  
Clifmar Rd.

(If rural, give LOCATION)

2. (a) If veteran, name war.....

## 3. (b) Social Security Number

220-07-9073

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....  
Apr. 4, 1946, at 2:15A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 1941 to Apr. 4, 1946,  
and that I last saw her alive on April 3, 1946.

Immediate cause of death.....  
Arteriosclerosis cerebral

Obit.....  
Cardiovascular Dis

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE.....  
Wm. E. Martin

M. D. or other

Address.....  
Randallstown

Date signed 4/4/46



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 150

03484

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

Baltimore  
County.....  
City or town..... Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yrs., 1 month, 8 days

Hospital, institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 3 yrs., 1 month, 8 days

## 3. (a) FULL NAME

William Dell

## 3. (b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

male white widowed

6.(b) Name of husband or wife Mary Pierce

7. Birth date of deceased (mo., day, yr.) November 23, 1874

6.(c) If alive, give age years

8. AGE: Years Months Days If less than one day  
71 5 3 . hrs. . min.9. Birthplace Baltimore County, Maryland  
(Town, county, and state)

10. Usual occupation Weaver

11. Industry or business Weaving

MOTHER FATHER 12. Name Nelson Dell

13. Birthplace Baltimore County, Maryland

14. Maiden name Mary Davis

15. Birthplace Baltimore County, Maryland

16. Informant Hospital records

Address Catonsville-28, Maryland

17. Burial Date thereof May 3, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Spring Grove State Hospital

Location Catonsville 28, Maryland

18. Funeral director Spring Grove State Hospital

Address Catonsville 28, Maryland

19. 5-4-1946 Harry D. Miller  
(Date by registrar) Deputy Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County.....

City or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No. 300 Carey Street  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 26 1946 at 10:25 a.m.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from March 18 1943 to April 26 1946 and that I last saw him alive on April 26 1946

Immediate cause of death Carcinoma of right maxilla

DURATION Indef.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

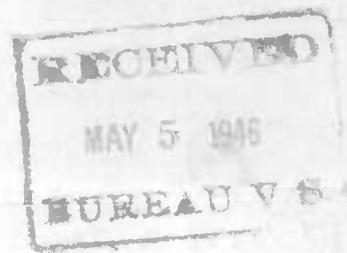
Means of injury

Injured at work?

Isadore Tuerk, M.D.

23. SIGNATURE Isadore Tuerk, M.D. M. D. or other

Address Catonsville-28, Md. Date signed 5-2-46



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore B.B.

63485

## CERTIFICATE OF DEATH

Reg. Dist. No. 32

## 1. PLACE OF DEATH:

County..... Baltimore

City or town.....

Mount Wilson

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 yrs., 11 mos., 30 days

Hospital, institution, or street address where death occurred Mt. Wilson

Branch, Md. Tuberculosis Sanatorium

How long in hospital or institution? 4 yrs., 11 mos., 30 days

## 3. (a) FULL NAME

Mrs. Frances M. Delozier

## 4. Sex

Female

## 5. Color or race

White

## 6.(a) Single, married, widowed, or divorced

Married

## 6.(b) Name of husband or wife..... John Delozier

6.(c) If alive, give age 45 years

## 7. Birth date of deceased (mo., day, yr.) July 9, 1908

8. AGE: Years 37 Months 9 Days 15 If less than one day hrs. min.

## 9. Birthplace..... Nottingham, Maryland

(Town, county, and state)

## 10. Usual occupation..... Housewife

## 11. Industry or business

12. Name..... Thomas Layman

13. Birthplace..... Maryland

14. Maiden name..... Mary E. Rawlings

15. Birthplace..... Maryland

## 16. Informant..... Mrs. Frances M. Delozier

Address R. #2, Anacostia, Oxen Hill, Md.

## 17. Burial Date thereof..... April 27, 1946

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Church of Assumption Cem.

Location..... Upper Marlboro, Maryland

## 18. Funeral director..... Ullrich Funeral Home

Address 2004 Orleans St., Balto., Md.

## 19. April 24, 1946

(Date rec'd by registrar)

Earl T Webster

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Prince Geo. Co.

City or town..... Anacostia, Oxen Hill

(If outside city or town limits, write RURAL and give nearest town)

Street No. \$ R. # 2.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... April 24, 1946 at 8:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 25, 1941, to April 24, 1946, and that I last saw her alive on April 24, 1946.

## Immediate cause of death.....

Pulmonary Tuberculosis

DURATION

6 Yrs.

Due to..... Tubercle Bacilli

Due to.....

Other conditions..... Amyloidosis

(Include pregnancy within 8 months of death)

Major findings of operations..... No operation

Date of op.

## Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury.....

Injured at work?

## 23. SIGNATURE.....

Stewart J Shaffer M.D.

M.D. or other

Address..... Mount Wilson, Md. Date signed..... 4/24/46

Rec'd 4-27-46

RECEIVED

APR 29 1946

BUREAU OF

PLEASE WRITE PLAINLY, WITH ENFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 50

63485

## CERTIFICATE OF DEATH

Reg. Distr. No. 31

## 1. PLACE OF DEATH

County ..... Baltimore  
 City or town ..... Fulton Ave. near Randalltown  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex

Female White Married  
 Pettingman Disbavon

5. Color or race

6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Years Months Days If less than one day  
 35 2 20 hrs. min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

Father ..... Charles A. Smith  
 12. Name

Mother ..... Unknown  
 13. Birthplace

Maiden name ..... Unknown Mrs. Smith  
 14. Birthplace

16. Informant ..... (Pettingman Disbavon)  
 Address ..... Fulton Ave. near Randalltown

Burial ..... Date thereof ..... 4-9-46  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory ..... Mt. Olivet Cemetery  
 Location ..... Randallstown

18. Funeral director ..... Wm. Cook Inc.

Address ..... 1217 St. Paul St.

19. (Date rec'd by registrar) ..... 4/7/46 M. D. or other

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State ..... Maryland County ..... Baltimore  
 City or town ..... Rural (If outside city or town limits, write RURAL and give nearest town)  
 Street No. ..... Gilmore Ave. Randallstown  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

April 7, 1946, at

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1945 to April 7, 1946,  
 and that I last saw her alive on April 6, 1946.

Immediate cause of death

Carcinomatosis

Due to Carcinoma of Breast

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

Jean E. Martin M. D. or other  
 Address ..... Randallstown Date signed 4/7/46

RECEIVED

APR 9 1946

BUREAU V R

Evidence for change of year MARYLAND STATE DEPARTMENT OF HEALTH  
of birth of deceased is shown on 2411 N. Charles St., Baltimore (B-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 32

FILM No. 101 MAY 2 1948

1. PLACE OF DEATH:

County

Baltimore

City or town

Brooklandville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

1 yr.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

JOHN COOPER DORSEY

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

white

Married

6. (b) Name of husband or wife

Maryjorie M. Dorsey

7. Birth date of deceased (mo., day, yr.)

April 20 - 1896 1896

6. (c) If alive, give age 78 years

8. AGE:

Years

months

Days

If less than one day

52

1

hrs.

min.

9. Birthplace

Carroll Co. Md

(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

MOTHER FATHER

12. Name

Frank W. Dorsey

MOTHER FATHER

13. Birthplace

Howard Co. Md

MOTHER FATHER

14. Maiden name

Anna S. Pittie

MOTHER FATHER

15. Birthplace

Harpers Ferry, Maryland

MOTHER FATHER

16. Informant

Maryjorie Marjorie Dorsey

MOTHER FATHER

Address

Brooklandville, Maryland

MOTHER FATHER

17. Burial

Date thereof April 25-48

MOTHER FATHER

(Burial, cremation, or removal. Which?)

(month) (day) (year)

MOTHER FATHER

Cemetery or cemetery

Glenwood Ridge

MOTHER FATHER

Location

Pikesville, Maryland

MOTHER FATHER

18. Funeral director

Frank A. Gurnell

MOTHER FATHER

Address

Pikesville, Maryland

MOTHER FATHER

19. (Date rec'd by registrar)

4/24/48

MOTHER FATHER

Registrar

60 Michaels

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State Maryland County

City or town Brooklandville

(If outside city or town limits, write RURAL and give nearest town)

Street No. Isaac T. Hopper Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

unknown

MEDICAL CERTIFICATION

20. DATE OF DEATH April 22, 1948 at 3:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 21, 1948 to April 23, 1948

and that I last saw him alive on April 17, 1948

Immediate cause of death

Pulmonary tuberculosis

Due to Pulmonary tuberculosis

Due to Pulmonary tuberculosis 2 years

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Louis Adair

M. D. or other

1413 Patterson Rd. Baltimore Date signed 4/24/48



Evidence for addition of name  
of town where death occurred

is shown on

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

03488

FILM No. 101 APR 15 1946

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

**1. PLACE OF DEATH:**

County... Baltimore

City or town... White Marsh

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Box 110 Ebenezer Rd.

How long in hospital or institution?

**3. (a) FULL NAME**

Frank H. Drayer

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife Alice (Bender)

7. Birth date of deceased (mo., day, yr.) April 13 - 1896 6.(c) If alive, give age years

8. AGE: Years 47 Months  Days  If less than one day  hrs.  min.

9. Birthplace Baltimore Co. (Town, county, and state)

10. Usual occupation Mechanic, Garage operator

11. Industry or business Garage Operator

12. Name Henry Drayer

13. Birthplace Baltimore Co.

14. Maiden name Elizabeth Currie

15. Birthplace Baltimore

16. Informant Alice Drayer, wife

Address Box 110 Ebenezer Rd.

17. Burial Date thereof 4/19/46  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Bethany Redeemer

Location Baltimore Rd.

18. Funeral director John J. Connelly

Address 418 Eastern Ave. Essex 21

19. 4/19/46 1946 John J. Connelly  
(Date rec'd by registrar) Registrar

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State MD County Baltimore

City or town Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 110 Street Ebenezer Rd

(If rural, give LOCATION)

2.(a) If veteran, name war.

**3. (b) Social Security Number**

### MEDICAL CERTIFICATION

20. DATE OF DEATH April 6 19 46; a.m.  M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 25 19 42, to April 6 19 46

and that I last saw him alive on April 6 19 46

Immediate cause of death

Coronary Thrombosis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

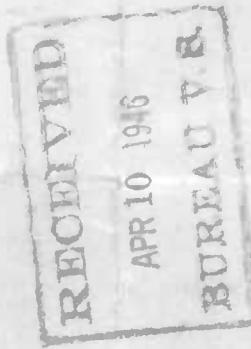
Means of Injury

Injured at work?

23. SIGNATURE

R. Drayer M.D. or other

Address Ridge Rd Baltimore 6 MD Date signed 4/8/46



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 4

03489 P

## CERTIFICATE OF DEATH

Reg. Dist. No. 104

1. PLACE OF DEATH *Baltimore Co - Md.*

County.....

City or town.....

Fort Howard,

(If outside city or town limits, write RURAL and give nearest town)

54 days

How long in above place of death?

Hospital, institution, or street address where death occurred:

Fort Howard, Md, Vets Adms.

How long in hospital or institution?

54 Days

## 3. (a) FULL NAME

James G. Drumm

4. Sex

White

5. Color or race

Male

6. (a) Single, married, widowed, or divorced

Divorced

8. (b) Name of husband or wife.....

8. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

6-9-98

8. AGE:

47

Years

Months

Days

If less than one day

hrs.

min.

Maryland

9. Birthplace.....

(Town, county, and state)

Dry Cleaner

10. Usual occupation.....

11. Industry or business

Charles Drumm

12. Name.....

Penn.

13. Birthplace

Ida D. Brown

14. Maiden name.....

Deleware

15. Birthplace

Clinical Records, Vets. Adms. Hosp.

16. Informant.....

Address Fort Howard, Maryland

Burial

Date thereof 4/24/46

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Odd Fellows Cemetery

Location .....

Seaford, Del.

18. Funeral director.....

Kenneth Thomas

Address

Cambridge, Md.

19. 4-22

19 46

(Date rec'd by registrar)

A. W. Cullison  
MD

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland

County.....

Cambridge

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 219 West End Ave

(If rural, give LOCATION)  
World War I

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 21

19 46 41 6:15 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2-26-46 to 4-21-46

and that I last saw h. alive on 4-21-46

Immediate cause of death

CARCINOMA: ADENO, CARDIAC END  
OF THE STOMACH WITH MESASTASIS

DURATION

4

Months  
plus

Due to.....

Due to.....

Anemia, Secondary to (1)

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury.....

Injured at work?

23. SIGNATURE R. M. CULLISON, MD. ACTING CLERK, DTR.

Address..... Date signed.....

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03490

Reg. Dist. No. 30

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

20 years

Hospital, institution, or street address where death occurred:.....

607 Hilton Ave.

How long in hospital or institution?.....

## 3. (a) FULL NAME

4. Sex

5. Color or race

6.(c) Single, married, widowed, or divorced

Female White Married

6.(b) Name of husband or wife.....

Percy C. Embrey

7. Birth date of deceased (mo., day, yr.)

Feb. 19, 1890

6.(c) If alive, give age.....

years

8. AGE: Years

Months

Days

If less than one day

56 1 15 hrs. min.

8. Birthplace.....

Baltimore, Balt. Co., Md.

(Town, county, and state)

10. Usual occupation.....

Housewife

11. Industry or business

MOTHER FATHER

12. Name.....

George J. Embrey

13. Birthplace.....

Germany

14. Maiden name.....

Hedwig Whisse

15. Birthplace.....

Germany

16. Informant.....

Percy C. Embrey

Address 607 Hilton Ave., Catonsville, Md.

17. Burial

Date thereof.....

(Burial, cremation, or removal, which?)

Apr. 6, 1946

(month) (day) (year)

Cemetery or crematory.....

London Park

Location.....

Baltimore, Md.

18. Funeral director.....

Easton, Sons

Address.....

608 Frederick Ave., Catonsville

19. 4-5

1946

Harold Muller

(Data rec'd by registrar)

20.

Deputy Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

None

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....

Apr. 3, 1946, at 9:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 8, 1946, to April 17, 1946

and that I last saw her alive on April 3, 1946

Immediate cause of death.....

Coronary Thrombosis

DURATION

Unknown

Due to..... Coronary Artery Sclerosis

Unknown

Due to..... Hypertensive Cardio-vascular disease

Unknown

Other conditions..... Diabetes Mellitus

Unknown

(Include pregnancy within 8 months of death)

Major findings of operations.....

None

Date of op.

Autopsy results.....

None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

## 23. SIGNATURE

M. L. Sengenzer M.D.

M. D. or other

1109 St Paul St

April 3, 1946

Date signed



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 490

## CERTIFICATE OF DEATH

03491 44  
Reg. Dist. No.

## 1. PLACE OF DEATH:

County... *Baltimore*City or town... *Sparrows Point*  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? *38 yrs.*Hospital, Institution, or street address where death occurred:  
*2000 Sp. Pt. Rd.*

How long in hospital or institution?

## 3. (a) FULL NAME

*Cora Lee Eppard*

## 3. (b) Social Security Number

4. Sex

*Female*

5. Color or race

*White*

6. (a) Single, married, widowed, or divorced

*married*

## 6. (b) Name of husband or wife

*Carnet L. Eppard*6. (c) If alive, give age *65*

years

7. Birth date of deceased (mo., day, yr.)

*Jan. 25 - 1885*

## 8. AGE:

Years

Months

Days

If less than one day

*61 3 0*

hrs.

min.

## 9. Birthplace

*Virginia*  
(town, county, and state)

## 10. Usual occupation

*Labour*

## 11. Industry or business

*Rheems mfg. co.*

## 12. Name

*Virginia medical*

## 13. Birthplace

*Va.*

## 14. Maiden name

*Emerson*

## 15. Birthplace

*"*

## 16. Informant

*Athene S. Eppard*Address *1718 Woodlawn Rd. Balt. 19*

## 17. Burial

Date thereof *April 27-46*  
(Burial, cremation, or removal. Which?)

(month) (day) (year)

## Cemetery or crematory

*Oak Lawn*

## Location

*Eastern Blvd.*

## 18. Funeral director

*John J. Connally*Address *416 Eastern Ave. Etobicoke*

(to)

(Date rec'd by registrar)

19. Date rec'd by registrar *Apr. 26 1946*

John J. Connally

Regular

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Md.*County *Baltimore*City or town *Sparrows Point*

(If outside city or town limits, write RURAL and give nearest town)

Street No. *2000 Sp. Pt. Rd.*

(If rural, give LOCATION)

## 2.(a) If veteran, name war

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

*April 28 - 1946 at 2:20 a.m.*

21. I CERTIFY that death occurred on the date above stand; that I attended deceased from

*March 15 - 1946 to April 28 - 1946*  
and that I last saw her alive on *April 28 - 1946*

## Immediate cause of death

*cardiac arrest*

DURATION

*7*

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

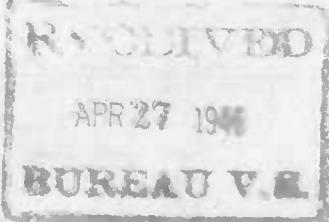
Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work? .....

23. SIGNATURE *John J. Connally, M.D.*

M. D. or other

Address *520 D St. Sparrows Point*Date signed *4-28-46*



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13d

03492

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

## 1. PLACE OF DEATH:

County.....

Baltimore

City or town.....

Middle River section

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

7 years.

Hospital, institution, or street address where death occurred:

Route 13, Box 297H, Balt. 21. Md.

How long in hospital or institution?.....

## 3. (a) FULL NAME

Ada M. Erick

4. Sex

F.

5. Color or race

W.

6.(a) Single, married, widowed or divorced

Married

6.(b) Name of husband or wife

George B. Erick

6.(c) If alive, give age

68

years

7. Birth date of

deceased (mo., day, yr.)

7 12 - 1881

8. AGE:

Years  
65Months  
2Days  
14

If less than one day

hrs.

min.

9. Birthplace.....

Baltimore Md.

(Town, county, and state)

10. Usual occupation.....

Housewife

11. Industry or business

MOTHER FATHER

12. Name..... Otis P. Thompson

13. Birthplace.....

Unknown

14. Maiden name.....

Unknown

15. Birthplace.....

George B. Erick

16. Informant.....

Route 13, Box 297H, Balt. 21. Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date hereof..... 4/19/46

(month) (day) (year)

Cemetery or crematory.....

Oaklawn

Location.....

Cemetery ave. Balt. Md.

18. Funeral director.....

Wm. D. Lee

Address.....

127 St Paul St. Balt. 2. Md.

19. 4/27

(Date rec'd by registrar)

1946

A.W. Hedrick

I Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland

County.....

Baltimore

City or town..... Middle River section

(If outside city or town limits, write RURAL and give nearest town)

Street No..... Route 13

Box 297H, Balt. 21. Md.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

WW

## 3. (b) Social Security Number

none

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....

April 26 1946 at 10:00 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 2 1946 to April 26 1946

and that I last saw her alive on April 26 1946

Immediate cause of death.....

Central Artery

DURATION

1 day

Due to.....

Hypertension Heart Disease

2 years

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

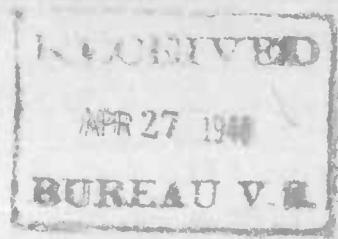
Means of injury..... Injured at work?

23. SIGNATURE.....

M. D. or other

Address.....

Eddy Rd. Date signed 4/26/46



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore B-6

03493

32

Reg. Dist. No.....

## CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:  
County..... Baltimore  
City or town..... Mount Wilson

(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 0 yrs., 0 mos., 10 days

Hospital, Institution, or street address where death occurred: Mt. Wilson Branch, Md. Tuberculosis Sanatorium

How long in hospital or institution? 0 yrs., 0 mos., 10 days

3. (a) FULL NAME  
Howard T. Faulkner

4. Sex Male	5. Color or race White	6. (a) Single, married, widowed, or divorced Married
----------------	---------------------------	---

6. (b) Name of husband or wife..... Mary E. Faulkner

7. Birth date of deceased (mo., day, yr.)  
August 7, 1888

8. AGE:	Years 57	Months 8	Days 10	If less than one day ..... hrs. ..... min.
---------	-------------	-------------	------------	---

9. Birthplace..... Centerville, Maryland  
(Town, county, and state)

10. Usual occupation..... Salesman

11. Industry or business

12. Name..... Nelson C. Faulkner

MOTHER FATHER  
13. Birthplace..... Caroline Co., Maryland

14. Maiden name..... Mary J. Carroll

15. Birthplace..... Hoopers Island, Maryland

16. Informant..... Howard T. Faulkner

Address..... 2520 Greenmount Ave., Balto., Md.

17. Burial..... Date thereof..... April 20, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Greenmount Cemetery

Location..... Hillsboro, Maryland

18. Funeral director..... John O. Mitchell & Sons

Address..... 1900 Eutaw Place, Balto., Md.

19. April 17, 1946..... Earl T. Webster  
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State..... Maryland County.....

City or town..... Baltimore  
(If outside city or town limits, write RURAL and give nearest town)

Street No..... 2520 Greenmount Avenue  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number  
No. Unknown

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... April 17, 1946, at 3:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 7, 1946, to April 17, 1946, and that I last saw him alive on April 17, 1946.

Immediate cause of death.....

Pulmonary Tuberculosis

DURATION

3 Yrs.

Due to..... Tubercle Bacilli

Due to.....

Other conditions..... Fatal Pulmonary Hemorrhage  
(Include pregnancy within 3 months of death)

Major findings or operations..... No operation

Date of op.

Autopsy results..... No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

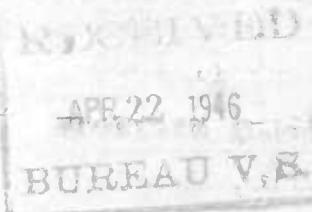
Injured at home, farm, industry, public place (where?)

Means of Injury..... Injured at work?

23. SIGNATURE..... Stewart S Shaffer M.D.  
M. D. or other

Address..... Mount Wilson, Md. Date signed..... 4/17/46

Reed 4-19-46 Dr. E E Nichols M.D.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 10

## CERTIFICATE OF DEATH

03494

38

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County..... Baltimore  
 City or town..... Towson 4, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Endwood Sanatorium, Towson 4, Md.

How long in hospital or institution?

## 3. (a) FULL NAME

Helen R. FRANZ

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Single

8. (b) Name of husband or wife.....

B. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

Nov 22, 1922

8. AGE:

Years  
23Months  
5Days  
4If less than one day  
hrs. ..... min.

9. Birthplace.....

(Town, county, and state)  
Baltimore Md

10. Usual occupation.....

Secretary

11. Industry or business

12. Name.....

I. C. Franz

13. Birthplace.....

Germany

14. Maiden name.....

Anna Hickey

15. Birthplace.....

Springfield, Mass.

## Personal History Hospital Records

13. Informant.....

Address..... Endwood Sanatorium, Towson 4, Md.

17. Burial.....

Date thereof..... 4-30-46  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....

Lorraine Cemetery

Location.....

Baltimore, Maryland

18. Funeral director.....

Soring Brooks

Address.....

5005 Park Heights Ave.

19. Date rec'd by registrar.....

4/29/46 A.M. 1946

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County.....

City or town..... Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No..... 5236 Linden Heights Ave  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

220-18-7741

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... April 27 1946 at 1 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 15 1946 to April 27 1946 and that I last saw her alive on April 26 1946

Immediate cause of death..... Pulmonary TB  
DURATION 4 yrs

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE..... W.A. Bridges

M. D. or other

Address..... Towson 4, Maryland

Date signed.....

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 19102

## CERTIFICATE OF DEATH

03495 30  
Reg. Dist. No.

## 1. PLACE OF DEATH:

County..... Baltimore

City or town..... Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yrs

Hospital, institution, or street address where death occurred: City of Baltimore

How long in hospital or institution? 4 mo.

## 3. (a) FULL NAME

Frank Bushay Hallion

3. (b) Social Security Number

None

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male White Married

6.(b) Name of husband or wife: May Hallion

7. Birth date of deceased (mo., day, yr.) Jan 24, 1868

6.(c) If alive, give age 69 years

8. AGE: Years 78 Months 2 Days 13 If less than one day hrs. min.

9. Birthplace: Howard Co Md

(Town, county, and state)

10. Usual occupation: Farmer - Retired

11. Industry or business

FATHER: 12. Name: George E. Hallion

13. Birthplace: Middlesex Co, Md.

MOTHER: 14. Maiden name: Anna M. Bushay

15. Birthplace: Frederick Co, Md.

16. Informant: Mrs. May Hallion

Address: 216 Bloomsbury Ave

Catoctin

17. Burial Date thereof: April 8, 1946

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory: Mt. View Cem.

Location: Slackers Corner Md

18. Funeral director: Easton Home

Address: 608 Frederick Ave Catonsville

19. 4-8 1946 Sheriff Miller

(Date rec'd by registrar) Deputy Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 216 Bloomsbury Ave

(If rural, give LOCATION)

2.(a) If veteran, name war: None

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Apr 6, 1946, at

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1 April 1946 to 5 April 1946

and that I last saw him alive on 5 April 1946

Immediate cause of death: Myocardial failure DURATION

Due to: Generalized arterio sclerosis heart disease

Due to: Muscular renal disease

Other conditions:

(Include pregnancy within 8 months of death)

## Major findings of operations:

Date of op.

## Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

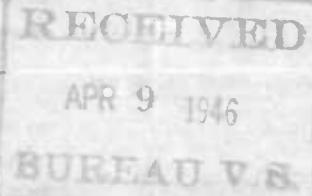
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Stephen Lee Magness MD M. D. or other

Address: 752 Frederick Ave Date signed: 7 April 1946



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03496

## CERTIFICATE OF DEATH

Reg. Dist. No. 38

## 1. PLACE OF DEATH:

Baltimore

County

Towson 4, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Since Oct 15, 1945

Hospital, institution, or street address where death occurred:

Eudowood Sanatorium, Towson 4, Md.

How long in hospital or institution?

Since Oct 15, 1945

## 3. (a) FULL NAME

Anne May Gifford

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

Sept 17, 1912

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

33 6

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

Baltimore Md

(Town, county, and state)

10. Usual occupation

Practical Nurse

11. Industry or business

Shepherd &amp; Bachrach Pratt Hosp.

MOTHER FATHER

Name

Walter Gifford

12. Name

Birthplace

Maryland - Baltimore

13. Birthplace

Anne Jones

14. Maiden name

Baltimore Md

15. Birthplace

Personal History-Hospital Records

16. Informant

Eudowood Sanatorium, Towson 4, Md.

Address

Burial

(Burial, cremation, or removal, Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

New Cathedral Cemetery

Location

Fred Ave. Bath Md.

John O'Connell

Funeral director

1900 Eutaw Place

Address

John O'Connell

Assistant

1946

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Maryland County Baltimore

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3409 Foster Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 4 1946, at 3:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 15, 1945, to April 4, 1946, and that I last saw her alive on April 3, 1946.

Immediate cause of death

Pulmonary Tuberculosis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

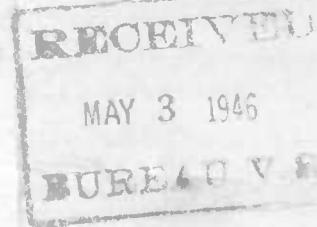
Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W.A. Bridges M. D. or other

Address Tows on 4, Md. Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 7

03497

P

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

County..... Balto.

City or town..... Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, Institution, or street address where death occurred:

Opitz Home - Edmondson Ave. &amp; Nunnery Lane

How long in hospital or institution?.....

## 3. (a) FULL NAME

GEORGE HENRY GLEIM

3. (b) Social Security Number  
none

4. Sex      5. Color or race      6. (a) Single, married, widowed, or divorced

Male      White      Married

6. (b) Name of husband or wife..... Gesina Gleim

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)..... March 22, 1864

8. AGE:      Years      Months      Days      If less than one day

82      0      18      hrs.      min.

9. Birthplace..... Baltimore, Md.

(Town, county, and state)

10. Usual occupation..... Retired

11. Industry or business..... Meat Packer (Own Business)

12. Name..... Nicholas Gleim

13. Birthplace..... Hessen, Germany

14. Maiden name..... Elizabeth Meyer

15. Birthplace..... Germany

16. Informant..... Mrs. Katharine Reid

Address..... 4400 Leeds Ave., Arbutus

17. Burial..... Date thereof..... 4/12/46  
(Burial, cremation, or removal. Which?)      (month) (day) (year)

Cemetery or crematory..... Loudon Park Cem.

Location..... Balto., Md.

18. Funeral director..... Wm. J. Wickner &amp; Sons

Address..... North and Pearson Aves.

4/11/46      A.W. Weddell

(Date rec'd by registrar)      Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md.      County..... Balto.

City or town..... Arbutus

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 4400 Leeds Ave.

(If rural, give LOCATION)

2. (a) If veteran, name war.....

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... April 10, 1946, at 8:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov 2, 1945, to April 10, 1946

and that I last saw h. m. alive on April 9, 1946

Immediate cause of death.....

Generalized arteriosclerosis  
Heart block

DURATION

3 yrs

3 yrs

Due to.....

Bilateral arteriosclerotic angiitis 2 mos

Due to.....

Heart failure with edema 7 feet 2 mos

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)      (County)      (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE..... Earl Pass M.D.

M. D. or other

Address..... 4001 Wilkens Ave. Date signed 4-11-46

## STATE OF MARYLAND—CERTIFICATE OF DEATH

13498

## 1. PLACE OF DEATH

County Baltimore

Village or City Fort Howard

Length of residence in city or town where death occurred

4 Minutes  
yrs. mos. ds.

No. Veterans Adm. Hospital.

St. Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)  
mos. ds. How long in U.S. if of foreign birth? yrs. mos. ds.

## 2. FULL NAME HENRY L. HAMM

(a) Residence: No. 2001 Maryland Ave., Balto., Md. Ward.

If nonresident give city or town and State

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
male	white	Married

5a. If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

Mrs. Dorothy Hamm

6. DATE OF BIRTH (month, day, and year) 1-12-1910

7. AGE	Years	Months	Days	If LESS than 1 day, _____ hrs. or _____ min.
36	3	12		

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Shipping Clerk

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month end year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Virginia  
(State or country)

13. NAME William Hamm

14. BIRTHPLACE (city or town) North Carolina  
(State or country)

15. MAIDEN NAME Regina Whorley

16. BIRTHPLACE (city or town) Virginia  
(State or country)17. INFORMANT Clinical Records, Vets. Adm. Hosp.  
(Address) Ft. Howard, Maryland

18. BURIAL, CREMATION, OR REMOVAL

Place Pittsburgh, Va. Date 19

19. UNDERTAKER Oder Funeral Home, Inc.  
(Address) 1614 York Rd., Balto., Md.20. FILED 5/11/46 DR McLearnone  
Registrar

## MEDICAL CERTIFICATE OF DEATH

## 21. DATE OF DEATH

april 22, 1946

(Month) (Day) (Year)

22. I HEREBY CERTIFY, That I attended deceased from April 22, 1946, to April 22, 1946.

I last saw him alive on April 22, 1946; death is said to have occurred on the date stated above, at 9:30 P.M.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

Subdural hemorrhage with generalized arteriosclerosis

Date of onset

Unknown

Other Contributory Causes of importance:

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? Autopsy Was there an autopsy? Yes

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury \_\_\_\_\_, 19\_\_\_\_\_

Where did injury occur?

(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury \_\_\_\_\_

Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased?

If so, specify Unknown

(Signed) J. McLearnone M.D. M. D.

(Address) 1614 Randolph St. N. E. Washington, D. C.

# UNITED STATES STANDARD CERTIFICATE OF DEATH

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

**Statement of cause of death.**—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

## Example I

The principal cause of death and related causes of importance were as follows:

Arteriosclerosis	
Chronic interstitial nephritis	
Cerebral hemorrhage	

MAY 24 1946

Other contributory causes of importance:

Gallstones	

Date of onset

1915

July 5, 1927

May 1, 1923

## Example II

The principal cause of death and related causes of importance were as follows:

Attack of epilepsy	
Run over by street car	
Peritonitis	

Date of onset

1 week ago

3 days ago

1 year

Other contributory causes of importance:

Gastroenteritis	

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

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## STATE OF MARYLAND—CERTIFICATE OF DEATH

## MARGIN RESERVED FOR BINDING

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1. PLACE OF DEATH

County

Baltimore

942

Registration Dist. No.

Village or City

Sparrows Point.

St. 3499

L

R

Ward

Length of residence in city or town where death occurred

yrs.

2

mos.

ds.

How long in U.S. if of foreign birth? yrs.

mos.

ds.

## 2. FULL NAME

(a) Residence: No.

Tyke Va., Green St., Co. Ward.

(Usual place of abode)

If nonresident give city or town and State

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male White Married

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

6a. If married, widowed, or divorced

HUSBAND of  
(or) WIFE of

Marion Gertrude.

6. DATE OF BIRTH (month, day, and year)

Oct 5 1866

7. AGE

Years Months Days

If LESS than  
1 day, \_\_\_\_ hrs.  
or \_\_\_\_ min.

79

6

2

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town)

Chesapeake

(State or country)

MOTHER FATHER

13. NAME Robert Hanna.

14. BIRTHPLACE (city or town)

Mary Va.

(State or country)

15. MAIDEN NAME Mary Douglas.

16. BIRTHPLACE (city or town)

Green Co Va

(State or country)

17. INFORMANT

Edward H. Hanna

(Address) 2405 Fairway Dr.

18. BURIAL, CREMATION, OR REMOVAL

Elkton, Md. Date 4. 10. 1946

19. UNDERTAKER

John C. Miller

(Address) 2405 Fairway Dr.

20. FILED

4826 Accidental

Registrar.

## MEDICAL CERTIFICATE OF DEATH

## 21. DATE OF DEATH

April 7, 1946.

(Month)

(Day)

(Year)

22. I HEREBY CERTIFY That I attended deceased from

Apr 7, 1946, to Apr 7, 1946

I last saw him alive on \_\_\_\_\_, 19\_\_\_\_; death is said to have occurred on the date stated above, at \_\_\_\_\_ m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

Coronary occlusion

Date of onset

Other Contributory Causes of importance:

Name of operation \_\_\_\_\_

Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_

Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? \_\_\_\_\_

Date of injury \_\_\_\_\_, 19\_\_\_\_

Where did injury occur? \_\_\_\_\_

(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE

Manner of Injury \_\_\_\_\_

Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased?

If so, specify \_\_\_\_\_

(Signed) John Barragaine M.D.

(Address) Deputy Medical Examiner

Randall, Md.

# UNITED STATES STANDARD CERTIFICATE OF DEATH

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write **none**.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

**Statement of cause of death.**—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

## Example I

The principal cause of death and related causes of importance were as follows:

	Date of onset
Arteriosclerosis	1915
Chronic interstitial nephritis	1921
Cerebral hemorrhage	July 5, 1927

Other contributory causes of importance:

Gallstones	May 1, 1923

## Example II

The principal cause of death and related causes of importance were as follows:

	Date of onset
Attack of epilepsy	1 week ago
Run over by street car	1 week ago
Peritonitis	3 days ago

Other contributory causes of importance:

Gastroenteritis	1 year

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 520

## CERTIFICATE OF DEATH

03500  
44  
Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:  
County.....*Baltimore*

City or town.....*Dundalk*  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

.....*905 Oakley Beach Ave.*

How long in hospital or institution?

3. (a) FULL NAME

*Robert Roy Harrison*

4. Sex      5. Color or race      6. (a) Single, married, widowed, or divorced

*M      W      married*

8. (b) Name of husband or wife.....*Eula Disharow*

*Harrison*      6. (c) If alive, give age.....years

7. Birth date of deceased (mo. day, yr.) *April 24 - 1887*

8. AGE:      Years      Months      Days      If less than one day  
*✓ 39                          hrs.      min.*

9. Birthplace.....*Va.*  
(Town, county, and state)

10. Usual occupation.....*Tool Crib.*

11. Industry or business.....*Rheems*

12. Name.....*Taylor Harrison*

13. Birthplace.....*Va.*

14. Maiden name.....*Ann Harrison*

15. Birthplace.....*Va.*

16. Informant.....*Mrs. Eula (Harrison, wife)*

Address.....*905 Oakley Beach Ave.*

17. Cremation.....*Date thereof.....*7/22/46**  
(Burial, cremation, or removal. Which?)  
(month) (day) (year)

Cemetery or crematory.....*Loudon Park*

Location.....*Frederick Rd.*

18. Funeral director.....*John D. Connally*

Address.....*418 Eastern Ave. Chesapeake*

19. 4/21/46.....19.....46.....*John D. Connally*

(Date rec'd by registrar)      Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State.....*MD*      County.....*Baltimore*

City or town.....*Dundalk*  
(If outside city or town limits, write RURAL and give nearest town)

Street No.....*905 Oakley Beach Ave*  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....*April 19 1946*

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from

*Jan 15 1946 to April 19 1946*

and that I last saw him alive on *April 18 1946*

Immediate cause of death.....

*Acute renal Kidney - R*

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

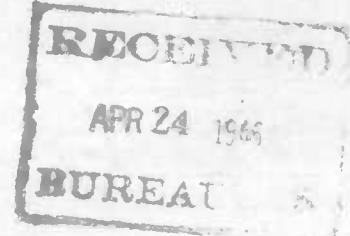
Where did injury occur? ..... (City or town)      (County)      (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE.....*DR [Signature]* M. D. or other

Address.....*520 1st St. [Signature]* Date signed.....*4/21/46*



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

03501

30

## CERTIFICATE OF DEATH

Reg. Dist. No.

## 1. PLACE OF DEATH:

County..... Baltimore

City or town..... Catonsville

(If outside city or town limits, write RURAL and give nearest town)

2 months, 9 days

How long in above place of death?

Hospital, institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution?

2 months, 9 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland

County.....

City or town..... Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 3633 Greenmount Avenue

(If rural, give LOCATION)

## 3. (a) FULL NAME

Edward Hart

4. Sex..... 5. Color or race..... 6.(a) Single, married, widowed, or divorced

Male..... White..... Single.....

6.(b) Name of husband or wife.....

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) September 5, 1909

8. AGE: Years..... Months..... Days..... If less than one day.....

36..... 7..... 24..... hrs..... min.....

9. Birthplace..... Baltimore, Maryland  
(Town, county, and state)

10. Usual occupation..... Paper hanger

11. Industry or business..... For himself

12. Name..... Edward L. Hart

13. Birthplace..... Virginia

14. Maiden name..... Annie Trader

15. Birthplace..... Virginia

16. Informant..... Hospital Records

Address..... Catonsville 28, Maryland

17. Burial, cremation, or removal?..... Date thereof..... 5/21/46  
(Buryal, cremation, or removal) Which?..... (month) (day) (year)

Cemetery or crematory..... Baltimore

Location..... Baltimore

18. Funeral director..... William G. Hedrich

Address..... 1219 1/2 Court

19. 51..... 19..... 86..... A. W. Hedrich  
(Date rec'd by registrar) S. M. Registrar

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... April 29, 1946, at 1:30 p.m.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

19..... to..... 19.....

and that I last saw him..... alive on..... 19.....

Immediate cause of death.....

Coronary occlusion

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Sudden death

Injury

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE..... G. W. Kieffer

M. D. or other

Address..... 1010 Leedale..... Date signed..... 4-29-46

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

03502

Reg. Dist. No. 30

PLEASE WRITE PLAINLY, WITH UPPERCASE LETTERS. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS A45 9-45-15M

## 1. PLACE OF DEATH:

County..... **Baltimore**City or town..... **Catonsville**

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? **1 year, 8 months, 15 days**

Hospital, institution, or street address where death occurred:

**Spring Grove State Hospital**How long in hospital or institution? **1 year, 8 months, 15 days**

## 3. (a) FULL NAME

**Joseph Hayden**

## 3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male

white

single

6. (b) Name of husband or wife.....

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

**June 22, 1860**

8. AGE: Years

Months

Days

If less than one day

85

10

13

hrs.

min.

9. Birthplace..... **Brooklyn, New York**

(Town, county, and state)

10. Usual occupation.....

**Marble worker (retired)**

11. Industry or business

**Marble**

12. Name.....

**Thomas Hayden**

13. Birthplace

**Ireland**

14. Maiden name.....

**Catherine Boyle**

15. Birthplace

**Ireland****Hospital records**

16. Informant.....

Address

**Catonsville-28, Maryland**

17. Buried

Date thereof..... **May 10, 1946**

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory.....

**Spring Grove State Hospital**

Location.....

**Catonsville 28, Maryland**

18. Funeral director.....

**Spring Grove State Hospital**

Address

**Catonsville 28, Maryland**19. (In the hands of registrar) **5-10 1946****Deputy Sheriff Muller**

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... **Maryland**

County.....

City or town.....

**Baltimore**

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

**725 South Bond Street**

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## MEDICAL CERTIFICATION

20. DATE OF DEATH **April 4**

19 46 at 8:45 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

**July 20, 1944**, to **April 4, 1946**.

and that I last saw him alive on

19.

Immediate cause of death.....

**D.K.****Broncho pneumonia, bilateral****Pulmonary tuberculosis**Due to..... **OIC**

DURATION

**2 days****Indefinit**

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results..... **as above**

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of

Where did injury occur? .....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) .....

Means of Injury.....

Injured at work?

**Isadore Tuerk, M.D.**

23. SIGNATURE.....

**Isadore Tuerk**

M. D. or other

Address..... **Catonsville-28, Maryland**Date signed **5-9-46**

RECEIVED

MAY 13 1946

BUREAU

**PLEASE WRITE PLAINLY, WITH UNFADING INK.** Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *(B.M.A.)*

## CERTIFICATE OF DEATH

03503  
Reg. Dist. No. 32

1. PLACE OF DEATH:  
Baltimore  
County.....

City or town..... Catonsville  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Opitz Home

How long in hospital or institution?

3. (a) FULL NAME

*Frederick J Hayes*

4. Sex      5. Color or race      6. (a) Single, married, widowed, or divorced

Male

White

Single

6. (b) Name of husband or wife..... --

6. (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.)      June 30, 1874

8. AGE:      Years      Months      Days      If less than one day  
71      9      19      hrs.      mts.9. Birthplace..... Pa.  
(Town, county, and state)

10. Usual occupation..... Retired

11. Industry or business

12. Name..... Michael Hayes

13. Birthplace..... Ireland

14. Maiden name..... Margaret Wright

15. Birthplace..... Ireland

16. Informant..... E. D. Laughlin

Address..... 3310 W. Liberty Ave., Pittsburgh

17. Removal..... Date thereof..... 4/19/46  
(Burial, cremation, or removal. Which?)      (month) (day) (year)

Cemetery or crematory..... Calvary Cem.

Location..... Pittsburgh, Pa.

18. Funeral director..... WM. J. TICKNER &amp; SONS

Address..... Baltimore, Md.

19. 4-19 - 1946  
(Date rec'd by registrar)2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State..... Md.      County.....

City or town..... Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No..... unknown  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... Apr 19 1946 at 10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr 10 1946 to Apr 19 1946, and that I last saw him alive on Apr 19 1946.

Immediate cause of death.....

*Hypertensive Cardiac Disease*  
*Congestive Heart Disease*

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) *Baltimore* (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... *Frederick Hayes*

M. D. or other

Address..... *Baltimore* Date signed 4-19

RECEIVED

APR 22 1946

BUREAU V.S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (940)

03504

P

## CERTIFICATE OF DEATH

Reg. Dist. No. X2

1. PLACE OF DEATH: BALTO e.  
 County .....  
 City or town ..... HALETHROPE - 27  
(If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 35 yrs.  
 Hospital, Institution, or street address where death occurred:

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
 State ..... MD County ..... BALTO e.  
 City or town ..... HALETHROPE - 27  
(If outside city or town limits, write RURAL and give nearest town)  
 Street No. 4712 WASH BLVD  
(If rural, give LOCATION)

How long in hospital or institution?

2.(a) If veteran, name war.

3. (a) FULL NAME MARGARET HELBIG  
 4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced WIDOWED  
 6. (b) Name of husband or wife O. RICHARD HELBIG (DEAD)  
 7. Birth date of deceased (mo., day, yr.) JULY 26 - 1862 8. (c) Marriage age 10 years  
 8. AGE: Years Months Days If less than one day  
 93 9 . . . . . hrs. . . . . min.  
 9. Birthplace GERMANY (Town, county, and state)  
 10. Usual occupation HOUSEWIFE  
 11. Industry or business  
 12. Name JOHN RLAUSMANN  
 MOTHER FATHER  
 13. Birthplace GERMANY  
 ?  
 14. Maiden name.  
 15. Birthplace GERMANY  
 16. Informant MRS ROSE OBST  
 Address 4712 WASH BLVD  
 17. BURIAL Date thereof 5. 4- 46  
(Burial, cremation, or removal, Month) (month) (day) (year)  
 Cemetery or columbarium LONDON PK.  
 Location C. T.Y.  
 18. Funeral director JOHN R KENNY  
 Address 1242 LEXTER. HALETHROPE 27  
 19. 5/3 19 X 6 A. W. Neubrich  
(Date rec'd by registrar) D.M. Registrar

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH April 30 1946 at 8:15 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1946, to April 30, 1946, and that I last saw her alive on April 27, 1946.

Immediate cause of death Bronchitis pneumonia

Due to Bronchitis pneumonia

Due to General debilitation

Other conditions Old age

(Include pregnancy within 3 months of death)

DURATION 126

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE G. S. May, M.D.

M. D. or other M. D. or other

Date signed 5/6/46

Dr. Bacon  
Taylor Avenue

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

0350538  
Reg. Dist. No. 3

## 1. PLACE OF DEATH:

County Carney

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 years

Hospital, institution, or street address where death occurred:

Harford Road &amp; Edwards Ave.

How long in hospital or institution?

## 3. (a) FULL NAME

Hilda Herr

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female white married

6.(b) Name of husband or wife Charles Herr, Jr.

7. Birth date of deceased (mo., day, yr.) Feb. 16, 1890

8. AGE: Years Months Days If less than one day  
56 1 23 hrs. min.9. Birthplace Germany  
(Town, county, and state)

10. Usual occupation At home

## 11. Industry or business

12. Name ?

13. Birthplace ?

14. Maiden name ?

15. Birthplace ?

16. Informant Mr. Charles Herr, Jr.

Address Harford Road &amp; Edwards Avenue

17. Burial Date thereof 4/10/46  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Parkwood

Location Baltimore

18. Funeral director Leonard J. Ruck

Address 5305 Harford Road 14

19. 4/19 19. 46  
(Date rec'd by registrar) G.W.Bacon  
Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carney

City or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No. Harford Road & Edwards Avenue  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 8th, 1946, at 5:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1935 to Apr - 8 1946  
and that I last saw her alive on Jan. 22 1946

Immediate cause of death

Coronary occlusion

Due to Chronic myocarditis  
Hyperextension

Due to

Other conditions Coronary occlusion 1935

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

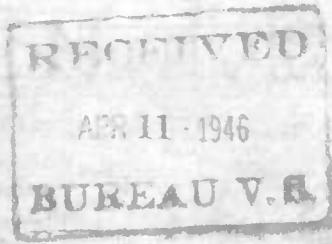
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?  
G.W. Bacon, M.D. by permission  
of Rollin C. Hudson, M.D. - D.M.E.23. SIGNATURE  
M. D. or other  
Address 2810 Taylor Ave. Date signed 4/9/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 3D-6

03506

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

County..... BaltimoreCity or town..... Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year, 11 mos., 21 days

Hospital, Institution, or street address where death occurred:

Spring Grove State HospitalHow long in hospital or institution? 1 year, 11 mos., 21 days

## 3. (a) FULL NAME

Amelia Hitchcock

## 3. (b) Social Security Number

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

female

white

married

6.(b) Name of husband or wife.....

Charles Hitchcock6.(c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.)

March 14, 1910

8. AGE:

Years

Months

Days

If less than one day

36

-

20

hrs.

min.

9. Birthplace.....

Havre de Grace, Maryland

(Town, county, and state)

10. Usual occupation.....

Waitress

11. Industry or business.....

Restaurant

12. Name.....

Fred Zellman

13. Birthplace.....

Germany

14. Maiden name.....

Martha Mitchell

15. Birthplace.....

Maryland

16. Informant.....

Hospital record

Address

Catonsville-28, Maryland

17. Burial.....

BurialDate thereof..... April 6/46

(Burial, cremation, or removal. Which?)

Cemetery or crematory.....

Jork Methodist

Location.....

Harford Co. Md.

18. Funeral director.....

Dean & Foster

Address

Bellair Motel

19. 4-5

1946

(Date signed by registrar)

Harry L. Miller  
Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... HarfordCity or town..... Aberdeen (If outside city or town limits, write RURAL and give nearest town)Street No..... RFD#1

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... April 3 19... 46, at... 5:30 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 13 19... 44, to... April 3 19... 46and that I last saw her..... alive on... April 3

Immediate cause of death.....

Cachexia

DURATION

3 weeksDue to..... General paresis

Indef.

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results..... none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury.....

Injured at work?

Devon Trust23. SIGNATURE..... Isadore Tuerk, M.D.

M. D. or other

Address..... Catonsville-28, Md. Date signed..... 4-4-46



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 50

03507

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County..... Baltimore Co.  
 City or town..... Chase Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Delia Holland

4. Sex      5. Color or race      6.(a) Single, married, widowed, or divorced

Female    White    Married

6.(b) Name of husband or wife..... Melvin Holland

7. Birth date of deceased (mo., day, yr.) ..... November 11, 1873

6.(c) If alive, give age ..... years

8. AGE:      Years      Months      Days      If less than one day  
72            4            25            hrs.            min.9. Birthplace..... Ireland  
(Town, county, and state)

10. Usual occupation..... Housewife

## 11. Industry or business

12. Name..... ? Gradey  
Ireland

13. Birthplace..... Ireland

14. Maiden name..... Potter

Ireland

15. Birthplace..... Melvin Holland

## 16. Informant

Address Green Bank Rd, Chase Md.

17. Burial..... Date thereof..... 4-9-1946  
(Burial, cremation, or removal. Which?)      (month) (day) (year)

Cemetery or crematory..... Cathedral

Location..... Baltimore Md.

18. Funeral director..... Flynn &amp; Fleming

Address 1426 Light Street

19. April 8 1946  
(Date rec'd by registrar)aw Hedrick  
Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md.      County..... Baltimore

City or town..... Chase

(If outside city or town limits, write RURAL and give nearest town)

Street No..... Green Bank Road

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... April 5, 1946      19      at 10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

November 19, 1945, to April 5, 1946, and that I last saw her alive on April 5, 1946.

Immediate cause of death..... Carcinoma

Liver

DURATION

6 mos

Due to..... Cancer Breast

3 yrs

Due to.....

Other conditions..... Arteriosclerosis - Gen.

Heart failure

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury.....

Injured at work? .....

23. SIGNATURE.....

M. D. or other

Address..... 815 Eastern Ave.      Date signed..... Apr 46

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 108

## CERTIFICATE OF DEATH

03568

Reg. Dist. No. XX

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:  
 County..... Baltimore  
 City or town..... Fort Howard  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... 3 Days.  
 Hospital, Institution, or street address where death occurred:  
 Vets. Adm. Hosp., Ft. Howard, Maryland  
 How long in hospital or Institution?..... 3 Days.

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State..... Maryland County.....  
 City or town..... Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No..... 1019 Forrest St., Baltimore, Md.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war..... ★ WW-2

## 3. (a) FULL NAME

LEROY HOLLIDAY

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Married

6. (b) Name of husband or wife..... Alice Holliday  
 7. Birth date of deceased (mo. day. yr.)..... 6. (c) If alive, give age..... 36 years  
 1-26-00 (Jan. 26, 1900)

8. AGE:	Years	Months	Days	If less than one day
	46	2	26	hrs. min.

9. Birthplace..... Michigan  
 (Town, county, and state)

10. Usual occupation..... Lather

11. Industry or business

MOTHER FATHER	12. Name..... Joseph Holliday
	13. Birthplace Michigan

MOTHER	14. Maiden name..... Annie Wales
	15. Birthplace Canada

16. Informant..... Clinical Records, Vets. Adm. Hospt.  
 Address..... Fort Howard, Maryland

17. Burial..... Date thereof..... 4/26/46  
 (Burial, cremation, or removal, which?) (month) (day) (year)  
 Cemetery or crematory..... National Cemetery

Location..... Baltimore, Maryland  
 18. Funeral director..... Wm. Cook, Inc.

Address..... 1217 St. Paul St., Baltimore, Md.

19. 4/24/46  
 (Date rec'd by registrar)

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... April 22, 1946, at 9:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 19, 1946, to April 22, 1946, and that I last saw him alive on April 22, 1946.

Immediate cause of death..... Pneumonia, lobar

DURATION

1 Day

Due to.....

Due to.....

Other conditions..... Acute alcoholism

(Include pregnancy within 8 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... Robert M. Cullison

R.M. CULLISON, M.D. ACT. M.D. other

Address..... Fort Howard, Maryland Date signed..... 4-23-46

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

## CERTIFICATE OF DEATH

Reg. Dist. No. 035030

P

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:  
 County..... Baltimore  
 City or town..... Catonsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... 3 months, 7 days  
 Hospital, institution, or street address where death occurred:..... Spring Grove State Hospital  
 How long in hospital or institution?..... 3 months, 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State..... Maryland County.....  
 City or town..... Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No..... 2709 Kennedy Avenue  
 (If rural, give LOCATION)

3. (a) FULL NAME..... Joseph B. Jones  
 4. Sex..... male 5. Color or race..... white 6.(a) Single, married, widowed, or divorced..... widowed  
 6.(b) Name of husband or wife..... Ella G. Chaney  
 7. Birth date of deceased (mo., day, yr.)..... February 10, 1878  
 8. AGE: Years..... 68 Months..... 2 Days..... 1 If less than one day..... hrs. ..... min.  
 9. Birthplace..... Baltimore, Maryland  
 (Town, county, and state)  
 10. Usual occupation..... Shipping clerk  
 11. Industry or business..... Shipping Sharp & Dolence  
 MOTHER FATHER  
 12. Name..... Charles W. Jones  
 13. Birthplace..... Baltimore, Maryland  
 14. Maiden name..... ?  
 15. Birthplace..... ?  
 16. Informant..... Hospital records  
 Address..... Catonsville-28, Md.  
 17. Burial..... Burial Date thereof..... 4/15/46  
 (Burial, cremation, or removal, which?) Cemetery or crematory..... Balto.  
 Location..... " Md.  
 18. Funeral director..... William Cook Inc.  
 Address..... 1217 St. Paul St.  
 19. (State of) by registrar..... 4-13 1946 And Hedgeman  
 (State of) Registrar..... addy

3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... April 11 1946 at 9:25 a.m.  
 21. I CERTIFY that death occurred on the date above stated: that I attended deceased from January 4 1946 to April 11 1946 and that I last saw him alive on April 11 1946.  
 Immediate cause of death..... Terminal pneumonia  
 DURATION..... 12 hours  
 Due to..... Arteriosclerotic cardiovascular disease  
 DUR.... Indef.  
 Due to.....  
 Other conditions.....  
 (Include pregnancy within 8 months of death)  
 Major findings of operations..... Date of op.  
 Autopsy results..... None  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.  
 22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....  
 Where did injury occur?..... (City or town)..... (County)..... (State)  
 Injured at home, farm, industry, public place (where?).....  
 Means of Injury..... Injured at work?  
 23. SIGNATURE..... Isadore Tuerk, M.D.  
 M. D. or other.....  
 Address..... Catonsville-28, Md. Date signed..... 4-11-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 23d

03510

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

County Baltimore

City or town Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex

5. Color of face

6.(a) Single, married, widowed, or divorced

Male White Married

6.(b) Name of husband or wife

Emma

7. Birth date of deceased (mo., day, yr.)

Jan 1870

6.(c) If alive, give age years

8. AGE: Years Months Days If less than one day

76 3 22 hrs. min.

9. Birthplace

(Town, county, and state)

Baltimore MD

10. Usual occupation

Lafayette Cock Retired

11. Industry or business

William C Jones

12. Name

Baltimore MD

13. Birthplace

Elizabeth J Larson

14. Maiden name

Baltimore MD

15. Birthplace

George E Mc Gowan

16. Informant

Address 718 E 36th

Date thereof 4/9/46

(Burial, cremation, or removal, Which?)

Cemetery or crematory London Park

Location Baltimore MD

18. Funeral director

Address 1217 St Paul St

Date rec'd by registrar April 8 1946

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County Baltimore

City or town

Catonsville

Street No.

11 N Murray Lane

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 6 1946 at 89 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 4 1946 to April 6 1946

and that I last saw him alive on April 5 1946

Immediate cause of death Coronary Thrombosis DURATION

Cardio-Vascular Disease Sudden

Due to

Other

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Eliot W Johnson MD

M. D. or other

Address 3432 Frederick Ave Date signed April 16/46

(Date signed)

Evidence for addition of MARYLAND STATE DEPARTMENT OF HEALTH  
age & birth date of deceased is shown  
on 2411 N. Charles St., Baltimore *B10*  
FILM No. 101 APR 29 1946

03511

## CERTIFICATE OF DEATH

Reg. Dist. No.

37

## 1. PLACE OF DEATH:

County *Baltimore*City or town *Texas*

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: *Balto. Co. Hospital*Stay in hospital or inst. (yrs., or mos., or days) *3 yrs. 7 mos. 6 da*Stay in this community (yrs., or mos., or days) *3 yrs. 7 mos. 6 da*

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Maryland* County *Baltimore*City or town *Jessey* Ward No. \_\_\_\_\_

Street No. \_\_\_\_\_

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR 

## 3. (a) FULL NAME

*Mary Jordan*4. Sex *Female* Col. 5. Color or race *Married*

6.(a) Single, married, widowed, or divorced

6(b) Name of husband or wife *Charles Jordan*7. Birth date of deceased (mo., day, yr.) *March 10, 1860*

6(c) If alive, give age \_\_\_\_\_ years

8. AGE: Years *86* Months *4* Days *1* If less than one day *hrs. 0 min.*9. Birthplace *Maryland*  
(Town, county, and state)10. Usual occupation *Housework*

## 11. Industry or business

12. Name *Francis Coleman*13. Birthplace *Maryland*14. Maiden name *Ethel Hall*15. Birthplace *Maryland*16. Informant *Pestor - St. Stephen's Church*Address *1603 Eastern Ave. Essex, Md.*17. Burial Date thereof *Apr. 11 1946*  
(Burial, cremation, or removal. Which?) *(month) (day) (year)*Cemetery or crematory *St. Stephen's Cemetery*Location *Essex, Md.*18. Funeral director *Mrs. Robt A. Elliott*Address *1129 W. Caroline St. Md.*19. *April 1-8 1946 Wm J. Wilcox*  
(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH *Apr. 8 1946*

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

*9/2 1942* to *Apr. 8 1946*, and that I last saw her *alive* on *4/7 1946*.Immediate cause of death *Chronic Nephritis*  
*Urinary Calculus -* DURATION *2 yrs.*Due to *arterio sclerosis*Due to *Sanity*

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings:

Of operations

Of autopsy

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

## Means of injury

Injured at work?

## 23. SIGNATURE

*Wilmer C. Eason Jr.* M. D. or otherAddress *Cockeysville Md.* Date signed *4/9/46*

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15 T



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

03512 8d

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County ..... Baltimore  
 City or town ..... Catonsville  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? .....

Hospital, institution, or street address where death occurred:

Opitz Nursing Home

How long in hospital or institution? .....

5 Mo.

## 3. (a) FULL NAME

KATE CATHERINE JOSLIN

4. Sex

Female

5. Color or race

white

6.(a) Single, married, widowed, or divorced

widowed

6.(b) Name of husband or wife

George H. Joslin

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.)

March 28, 1860

8. AGE:

Years  
86Months  
0Days  
27

If less than one day

hrs. ..... min.

9. Birthplace ..... Baltimore, Maryland

(Town, county, and state)

10. Usual occupation.....

Housewife

11. Industry or business

12. Name ..... John Rheinhardt

13. Birthplace ..... Baltimore, Maryland

14. Maiden name ..... Unknown

15. Birthplace .....

16. Informant ..... Mr. Wilbur A. Joslin - son

Address

Burial

4-29-46

(Burial, cremation, or removal. Which?)

Date thereof ..... (month) (day) (year)

Cemetery or crematory .....

Loudon Park Cemetery

Location .....

Baltimore, Maryland

18. Funeral director .....

HENRY SANDER &amp; SONS, INC.

Address

NORTH AVE. &amp; BROADWAY

19. ....

4-26-46

(Date rec'd by registrar)

19.

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State ..... Md. County ..... Baltimore

City or town ..... Baltimore - Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No. .... 704 Old Home Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number  
no

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Apr 25 1946, at 12:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 2 1946, to Apr 25 1946,

and that I last saw her alive on Apr 24 1946.

Immediate cause of death

Barbituric acid

DURATION

1 yr

Due to

Due to

Other conditions

Decayed teeth

Gum disease

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address ..... Date signed ..... Apr 25

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (6)

## CERTIFICATE OF DEATH

P  
03513  
Reg. Dist. No. 44

## 1. PLACE OF DEATH

County.....

City or town.....

Baltimore  
Middle River

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

42 yrs

Hospital, Institution, street address where death occurred:

2120 Oakland Ave

How long in hospital or institution?.....

## 3. (a) FULL NAME

SARAH KAPLAN.

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

FEMALE

WHITE

MARRIED.

6. (b) Name of husband or wife.....

Louis

7. Birth date of deceased (mo., day, yr.)

1884

8. (c) If alive, give age.....years

8. AGE:

Years  
62

Months

Days

It less than one day

hrs.

min.

9. Birthplace.....

(Town, county, and state)

Russia

10. Usual occupation.....

Housewife

11. Industry or business.....

MOTHER FATHER

12. Name.....

Samuel

Russia

Russia

13. Birthplace.....

Russia

Russia

14. Maiden name.....

Reba Gita

Russia

Russia

15. Birthplace.....

Russia

Russia

16. Intertomb.....

Louis Kaplan

2120 Oakland Ave

Burial

(Burial, cremation, or removal. Which?)

Cemetery or crematory.....

Bellevue Nursing Home

Location.....

Face Lewis Inc

Address.....

1429 E. Balt. St

19. (Date record by registrar)

4/3 1946

F. W. Hedrick

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

City or town.....

Street No. ....

County.....

(If outside city or town limits, write RURAL and give nearest town)

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

APRIL 2 -

1946

at 12:17 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 9 1943 to APRIL 2 1946.

and that I last saw h. ER. alive on APRIL 1 1946.

Immediate cause of death.....

Central Thrombosis

Due to..... Central Arteriosclerosis

Due to.....

Other conditions..... Diabetes mellitus

6 mos

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... John Miller

M. D. or other

Address..... Ridge Road

Date signed 4/2/46.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13

03514

## CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:  
County..... Balto.

City or town..... 15W20  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:  
221 Regester Ave.

How long in hospital or institution?

## 3. (a) FULL NAME

JOHN W. KARFGIN

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife..... Virginia Turner Karfgin

6.(c) If alive, give age ..... years  
7. Birth date of deceased (mo., day, yr.) April 4, 1904

8. AGE:	Years	Months	Days	If less than one day
	42	0	19	hrs. min.

9. Birthplace..... Balto., Md.  
(Town, county, and state)

10. Usual occupation..... Insurance Broker

11. Industry or business..... Poor-Bowen-Bartlett & Kennedy

MOTHER FATHER  
12. Name..... Clemens Karfgin, Sr.

13. Birthplace..... Baltimore, Md.

14. Maiden name..... Gertrude Eisselman

15. Birthplace..... Baltimore, Md.

16. Informant..... Mr. Walter E. Karfgin

Address..... 4331 Harford Rd.

17. Burial..... Date thereof..... 4/25/46  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Western Cem.

Location..... Balto., Md.

18. Funeral director..... WM. J. TICKNER & SONS

Address..... Balto., Md.

19. (Date rec'd by registrar) 4/24/46 A.W. Hedrick  
D.M. Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State..... County..... Balto.

City or town..... Town  
(If outside city or town limits, write RURAL and give nearest town)

Street No..... 221 Regester Ave.  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

212-07-2628

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... April 23, 1946, at 6:40 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

VAN 1946 to APRIL 23, 1946

and that I last saw him alive on April 23, 1946

Immediate cause of death..... Pulmonary Tuberculosis  
Tuberclosis of Primary Tract

DURATION

1946  
1946

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... Walter E. Karfgin  
4331 Harford Rd. M. D. or other

Date signed..... 4/23/46

## MARGIN RESERVED FOR BINDING

N.B.—WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## STATE OF MARYLAND—CERTIFICATE OF DEATH

03515

P

## 1. PLACE OF DEATH

County

Baltimore

74a

Registration Dist. N.D.

74

Village or City

Applause Point Md.

No. 709 East

St.

Ward

Length of residence in city or town where death occurred

42 yrs.

mos.

ds.

How long in U.S. if of foreign birth?

yrs.

mos.

ds.

## 2. FULL NAME

Charles Edward Keys.

(a) Residence: No.

709 East

St.

Ward.

If nonresident give city or town and State

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male White Married

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED,  
OR DIVORCED (write the word)

5a. If married, widowed, or divorced

HUSBAND OF  
(or) WIFE OF

Sarah Edna.

6. DATE OF BIRTH (month, day, and year)

July 30/1873

7. AGE

Years

Months

Days

If LESS than

1 day, \_\_\_\_ hrs.  
or \_\_\_\_ min.

72 9 17

## OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (Month and year)

July 13/46

11. Total time (years)  
spent in this occupation

42 yrs.

12. BIRTHPLACE (city or town)

(State or country)

Baltimore Md.

## MOTHER FATHER

13. NAME

Thos W. Keys

14. BIRTHPLACE (city or town)

(State or country)

Maryland

15. MAIDEN NAME

Don't know

16. BIRTHPLACE (city or town)

(State or country)

Md

17. INFIRMANT

(Address)

Mrs Sarah Keys

709 East Sparrows Pt

18. BURIAL, CREMATION, OR REMOVAL

Place

Mt Zion Cem.

Date April 17, 1946

19. UNDERTAKER

(Address)

Allrich Funeral Home

2008 Decatur St.

20. FILED

X/15/46

A. W. Gedrich

Registrar.

## MEDICAL CERTIFICATE OF DEATH

## 21. DATE OF DEATH

April 13, 1946

(Month)

(Day)

(Year)

## 22. I HEREBY CERTIFY, That I attended deceased from

April 13, 1946, to

19

I last saw h. alive on , 19 ; death is said to have occurred on the date stated above, at m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

Coronary Occlusion

Date of onset

2 hrs.

Other Contributory Causes of importance:

Hypertension

?

Name of operation

Date of

What test confirmed diagnosis?

Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide?

Date of injury , 19

Where did injury occur?

(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

Dr Maguire M.D.

Deputy Medical Examiner

Division of Health

# UNITED STATES STANDARD CERTIFICATE OF DEATH

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

**Statement of cause of death.**—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:

	Date of onset
Arteriosclerosis	1915
Chronic interstitial nephritis	1921
Cerebral hemorrhage	July 5, 1927

Example II

The principal cause of death and related causes of importance were as follows:

	Date of onset
Attack of epilepsy	1 week ago
Run over by street car	1 week ago
Peritonitis	3 days ago

Other contributory causes of importance:

Gallstones	May 1, 1923

Other contributory causes of importance:

Gastroenteritis	1 year

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1640

## CERTIFICATE OF DEATH

03516  
Reg. Dist. No. 38

## 1. PLACE OF DEATH:

Baltimore  
County.....  
City or town..... Towson 4 Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9/22/1946 to 4/6/46.

Hospital, Institution, or street address where death occurred:

Eudowood Sanatorium, Towson 4, Md.  
How long in hospital or institution? 5 yrs, 7 mo. 13 days

## 3. (a) FULL NAME

Carl Kidwell

## 3. (b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Male white married

6.(b) Name of husband or wife Henrietta Kidwell

7. Birth date of deceased (mo. day, yr.) March 5, 1888.

8. AGE: Years Months Days If less than one day  
58 1 1 hrs. min.9. Birthplace Virginia  
(Town, county, and state)

10. Usual occupation Engineer

## 11. Industry or business

12. Name David Kidwell

13. Birthplace West Virginia

14. Maiden name Cornelia Lowrey

15. Birthplace Virginia

16. Informant Personan records-Hospital  
records Eudowood Sanatorium, Towson Md.  
Address17. Burial Date thereof 4-9-46  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mt Lebanon

Location Winchester Va

18. Funeral director Rev. W. Donaldson

Address 416 Daniel St

19. (Date record by registrar) 4/6/46 Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County Prince George

City or town..... Laurel  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1007 Montgomery st.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 6 1946 at 7:40 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw h. alive on 19 te 19

Immediate cause of death Shot thru chest and heart Suicide

Depression

Due to Pulmonary tuberculosis, advanced 1933

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Suicide Date of 4/6/46

Where did injury occur? Towson (City or town) Baltimore (County) Md. (State)

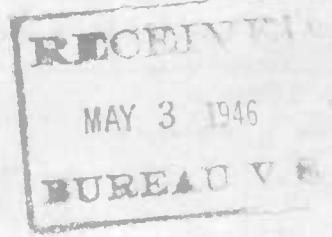
Injured at home, farm, industry, public place (where?) Hospital (Eudowood)

Means of Injury 32 revolver, suicide injured at work

23. SIGNATURE

Bolling C. Hudson M.D. D.M.E. M. D. or other

Address Towson Md. Date signed 4/6/46



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13.

03517

## CERTIFICATE OF DEATH

Reg. Dist. No. 32

## 1. PLACE OF DEATH:

Baltimore

County

Mount Wilson

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 0 yrs., 2 mos., 10 days

Hospital, Institution, or street address where death occurred: Mt. Wilson

Branch, Md. Tuberculosis Sanatorium

How long in hospital or institution? 0 yrs., 2 mos., 10 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Maryland

State

Montgomery

County

Silver Spring

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No. 618 Sligo Avenue

Street

(If rural, give LOCATION)

2.(a) If veteran, name war.

## 3. (a) FULL NAME

Joseph H. Kirby

## 3. (b) Social Security Number

578-32-5633

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

Ruth Kirby

7. Birth date of deceased (mo. day, yr.)

September 26, 1898

6.(c) If alive, give age

46

years

8. AGE:

Years

Months

Days

If less than one day

47

6

15

hrs.

min.

9. Birthplace

Virginia

(Town, county, and state)

10. Usual occupation

Fireman

11. Industry or business

Charles E. Kirby

12. Name

Mother Father

Virginia

13. Birthplace

Mother Father

Unknown

14. Maiden name

Mother Father

Rose B. Costello (?)

15. Birthplace

Mother Father

Unknown

16. Informant

Mother Father

Joseph H. Kirby

Address

Mother Father

618 Sligo Ave., Silver Spring,

17. Burial

Burial

Date thereof April 15, 1946

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Burial

Burtonsville Union

Location

Burial

Burtonsville, Maryland

18. Funeral director

Burial

Warner E. Pumphrey

Md.

Address

Burial

8434 Georgia Ave., Silver Spring,

19. Date rec'd by registrar

Burial

April 10, 1946

Earl J. Webster

Registrar

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 10, 1946, at 12:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 31, 1946, to April 10, 1946,

and that I last saw him alive on April 10, 1946.

Immediate cause of death

Pulmonary Tuberculosis

DURATION

1 yr.

9 mos.

Due to Tubercle Bacilli

Due to

Tuberculous Nephritis

1 yr. 9 mo.

Other conditions Cerebral Embolism

Urinary Calculi

Unknown

(Include pregnancy within 3 months of death)

Major findings of operations

No operation

Date of op.

Autopsy results

No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work

23. SIGNATURE

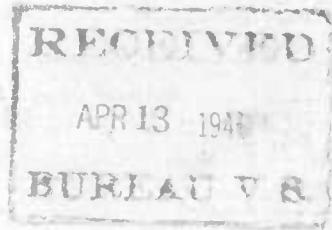
Stewart S Shaffer M.D.

M. D. or other

Address Mount Wilson, Md. Date signed 4/10/46

Registrars

Recd. 4-12-46 Dr. E. Nichols



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 77-C

03519

32

## CERTIFICATE OF DEATH

Reg. Dist. No.

## 1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Mt. Wilson Sanatorium

How long in hospital or institution?

## 3. (a) FULL NAME

Thos. Klemick

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male white unknown

## 6. (b) Name of husband or wife

Mary Klemick

## 7. Birth date of

deceased (mo., day, yr.)

6. (c) If alive, give age ..... years

8. AGE:

Years

Months

Days

If less than one day

about 47 hrs. min.

## 9. Birthplace.....

Chicago Ill.

(Town, city, and state)

## 10. Usual occupation.....

Saloner

## 11. Industry or business

Mt. Wilson Sanatorium

## 12. Name.....

Unknown

## 13. Birthplace.....

## 14. Maiden name.....

Unknown

## 15. Birthplace.....

## 16. Informant.....

Mt. Wilson Sanatorium

## Address

Burial Date thereof April 20, 46  
(Burial, cremation, or removal. Which?) Date (month) (day) (year)

Cemetery or crematory Balt. Material Cemetery

Location Frederick Rd. Balt. Md.

18. Funeral director Frank H. Yeager

Address Pikeville Maryland

19. 4-19- Date rec'd by registrar 1946 E. E. Nichols

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County.....

City or town (If outside city or town limits, write RURAL and give nearest town)

Street No. —

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 4 1946 at 2 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Apr 4 1946 to Apr 4 1946 and that I last saw him alive on April 4 1946

## Immediate cause of death

Acute alcoholism

DURATION 10 days

## Due to

## Due to

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op. none

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide none Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

## Means of Injury

## Injured at work?

23. SIGNATURE D. D. Caples M.D. M. D. or other

Address Rutherfordton, Md. Date signed 4-6-46



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *Bd*

## CERTIFICATE OF DEATH

03518  
Reg. Dist. No. 37

## 1. PLACE OF DEATH:

Baltimore  
City or town Cockeyville Md  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 yrs

Hospital, institution, or street address where death occurred:

Masonic Home, Cockeyville Md

How long in hospital or institution?

## 3. (a) FULL NAME

Mrs Mary Elizabeth Brington

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Widow

6. (b) Name of husband or wife Wesley H. Ernest

7. Birth date of deceased (mo., day, yr.) Nov. 6 - 1868

8. AGE: Years Months Days If less than one day  
77 5

hrs. min.

9. Birthplace Millerstown Pa.  
(Town, county, and state)

10. Usual occupation Seamstress

11. Industry or business

12. Name Wesley H. Ernest

13. Birthplace Millerstown Pa.

14. Maiden name Melinda Long

15. Birthplace Millerstown Pa.

16. Informant Laura M. Schröder

Address Masonic Home, Cockeyville Md

17. Burial Date thereof April 8 - 46  
(Burial, cremation, or removal. Which?)Date thereof April 8 - 46  
(month) (day) (year)

Cemetery or crematory Greenmount

Location Baltimore Md

18. Funeral director Geo. L. Breyer Jr.

Address 1512 Hollins St

19. April 6 - 46 L. M. Schröder

(late rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County

City or town Baltw. (If outside city or town limits, write RURAL and give nearest town)

Street No. 2411 Barclay St

(If rural, give LOCATION)

2.(a) Is veteran, name war.

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

2D. DATE OF DEATH April 5 1946 at 12:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1 1946 to April 5 1946

and that I last saw her alive on April 4 1946

Immediate cause of death Cardiac Failure

DURATION 1 day

Due to Coronary Thrombosis

Due to

Other conditions Congestive Heart Failure

Arteria Sclerotic C. V. D.

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

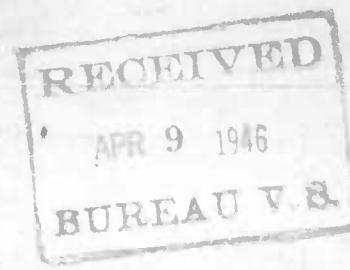
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert Baldwins M. D. or other

Address Panama Branch St. Eliz. H. C. T. Date signed 4/5/46



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

## CERTIFICATE OF DEATH

03520  
43

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## 1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Joseph F. Kraus

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male White Married

6.(b) Name of husband or wife

Johanna F.

7. Birth date of deceased (mo. day, yr.)

May 26 1897

6.(c) If alive, give age years

45

8. AGE:

Years Months Days 11 less than one day

48

11

18

hrs. min.

9. Birthplace

Baltimore Co.

(Town, county and state)

10. Usual occupation

Machinist

11. Industry or business

John Kraus

Father 12. Name

Germany

Mother 13. Birthplace

ESL 1864th Bacer

14. Maiden name

Germany

15. Birthplace

Vohanna F. Kraus

16. Informant

13 Foster Ave

Address

Baltimore

17. (Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

4/22/46

Cemetery or crematory

Walden Cemetery

Location

4200 Belair Rd

Mail Dr. B. D. Murphy

Address

2160 Belair Rd

18. Funeral director

A. W. Kegel

Date sec'd by registrar

4/22 1946

Registrar

SM

19. Date sec'd by registrar

4/22 1946

A. W. Kegel

Date signed

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md. County

City or town

Overlea (If outside city or town limits, write RURAL and give nearest town)

Street No.

13 Foster Ave. (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

717-07-7050

## MEDICAL CERTIFICATION

20. DATE OF DEATH

April 20 1946 at 8:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 1st 1946 to April 20 1946

and that I last saw him alive on April 15th 1946 1946

Immediate cause of death

Coronary Thrombosis DURATION 3 weeks

Due to

Due to

Other conditions the occurred in connection with the cause of death

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

Edward Benson M. D. or other

Address W. Overlea Date signed 4/22/46

## MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (B.V.S.)

Reg. Dist. No. 31

## CERTIFICATE OF DEATH

03521

## 1. PLACE OF DEATH:

(a) County Baltimore

(b) City or town Rockdale

(If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution:

3405 Rolling Road

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in this community (yrs., mos., or days)

## 3 (a) FULL NAME

Amelia M. Lages

3 (b) If veteran, name war

3 (c) Social Security

No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or  
divorced.

Female

White

Widowed

6 (b) Name of husband or wife Charles T. Lages

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 31, 1855

8. AGE: Years 90 Months 8 Days 10 If less than one day  
hr. min.

9. Birthplace Baltimore County, Md.

(Town, county, and state)

10. Usual occupation None

11. Industry or business

12. Name Mr. Snyder

13. Birthplace Germany

14. Maiden Name Catherine Groff

15. Birthplace Germany

16. (a) Informant Mrs. Lorenzo Kirk

(b) Address 3405 Rolling Rd., Rockdale

17. (a) Burial

(b) Date thereof Apr. 12, 1946

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Mt. Olive Cemetery

Location Randallstown, Md.

18. (a) Funeral director

(b) Address 1510 Liberty Hwy Ave.

19. (a) April 11, 1946 (b) Henry A. Orwige

(Date rec'd by registrar)

Registrar

## 2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town Rockdale

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3405 Rolling Road

(If rural give location)

(e) If foreign born, how long in U. S. A.? years

## MEDICAL CERTIFICATION

20. Date of death April 10 1946 at 1.45 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1943 to April 10 1946, and that I last saw him alive on April 10 1946.

Immediate cause of death

AUREMIA

Duration

2 WKS.

Due to NEPHRITIS, CHRONIC PARENCHYMALOS

3 yrs.

Due to HYPERTENSION

3

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

## PHYSICIAN

Underline the cause to which death should be charged statistically.

Of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

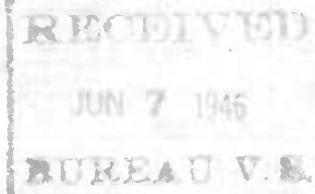
Dr. Hoffman, M.D.

M. D. or other

23. Signature

Address 8 E. Read St.

Date signed 4/10/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 50

03522

31

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County..... Baltimore County  
 City or town..... Woodlawn  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs.Hospital, Institution, or street address where death occurred: 5536 Hutton Ave

How long in hospital or institution?

## 3. (a) FULL NAME

Irma M. Lauver

## 4. Sex

Female	5. Color or race	6.(a) Single, married, widowed, or divorced
	White	Married

6.(b) Name of husband or wife..... George Lauver

7. Birth date of deceased (mo., day, yr.) July - 21 - 1894 8. (c) If alive, give age ..... years

8. AGE: Years 51 Months 8 Days 17 If less than one day hrs. min.

9. Birthplace..... Jersey City - N.J.  
(Town, county, and state)

10. Usual occupation..... House Wife

11. Industry or business..... At home

12. Name..... Joseph H. Rudiger

13. Birthplace..... Jersey City - N.J.

14. Maiden name..... Alma Hayes

15. Birthplace..... N.J.

16. Informant..... Mr. George Lauver

Address..... 5536 Hutton Ave.

17. Burial..... Burial Date thereof..... April 10 - 46  
(Burial, cremation, or removal. Which?)

Cemetery or crematory..... Lorraine Park Cemetery

Location..... Woodlawn - Md.

18. Funeral director..... Charles J. Schuyler

Address..... 505 N. Monroe St.

19. 4/9 1946 A.W. Hedrick  
(Date filed by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State..... Md. County..... Baltimore County  
 City or town..... Woodlawn  
 Street No..... 5536 Hutton Ave  
(If outside city or town limits, write RURAL and give nearest town)  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

218-12-2972

## MEDICAL CERTIFICATION

20. DATE OF DEATH April, 7th '46 1946 a. 8:45 p.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 31 1944 to Apr. 7 1946 and that I last saw her alive on April 7 1946.

Immediate cause of death..... Metastatic Carcinoma of Mediastinum and Stomach DURATION 16 mo.

Due to..... Primary Carcinoma Right Mammary Gland 2/9/22

Due to..... Mammary Gland 2/9/22

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... Carcinoma of Right Mammary Gland Date of op. 10/44

Autopsy results..... No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State).....

Injured at home, farm, industry, public place (where?) .....

Means of injury..... Injured at work?.....

23. SIGNATURE Joshua H. Aronson MD M. D. or other \_\_\_\_\_

Address..... 6419 Wisconsin Mill Rd Date signed April 9

Baltimore - 7 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 830

03523

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

County.....

Balto

City or town.....

Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

O'Hara Convalescent Home

How long in hospital or institution?

## 3. (a) FULL NAME

William A. Leitz

## 3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Widowed

6. (b) Name of husband or wife.....

Ella M. Leitz

6. (c) If alive, give age.....years

7. Birth date of deceased (mo., day, yr.)

Aug 10<sup>th</sup> 1856

8. AGE:

Years

Months

Days

If less than one day

89

8

10

hrs.

min.

9. Birthplace.....

Balto, Maryland

(Town, county, and state)

10. Usual occupation.....

Retired Electrician

11. Industry or business.....

Andrew Leitz

12. Name.....

Unknown

13. Birthplace.....

"

14. Maiden name.....

"

15. Birthplace.....

"

16. Informant.....

Raymond E. Leitz

Address

424 Edgewood St.

17. Burial.....

Burial

Date thereof.....

4/23/46

(Burial, cremation, or removal; When?)

(month) (day) (year)

Cemetery or cemetery.....

Western

Location.....

Balto, Md.

18. Funeral director.....

William Cook Inc.

Address

1257 St. Paul St.

19. 4-22-1946

(Date rec'd by registrar)

Austin J. Leitz

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md

County.....

Baltimore

City or town.....

Baltimore

Street No.....

424

Edgewood St

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....

4-20

19

46 at 12:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Apr 4 1946 to Apr 20 1946

and that I last saw him alive on Apr 20 1946

Immediate cause of death.....

Cerebral hemorrhage - 2 days

DURATION

Due to.....

Cerebral hemorrhage

Due to.....

Sclerosis

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....

James R. Leitz

M. D. or other

Address..... Date signed.....

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 164a

P

## CERTIFICATE OF DEATH

03524

Reg. Dist. No.....

## 1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex:

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age .....

years

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace.....

(Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

MOTHER

FATHER

12. Name.....

13. Birthplace.....

14. Maiden name.....

15. Birthplace.....

16. Informant.....

Address.....

17. Burial, cremation, or removal (which?)

Cemetery or crematory.....

Location.....

18. Funeral director.....

Address.....

19. (Date rec'd by registrar)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

City or town.....

Street No.....

(If outside city or town limits, write RURAL and give nearest town)

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH:

April 8

1946, at 7:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to.....

19.....

and that I last saw h.....alive on.....

Immediate cause of death.....

Starvation by  
starvation

DURATION

3 hrs.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

4-8-6

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Hanging

Injured at work?.....

23. SIGNATURE.....

Dr. J. B. Davis, M.D., or other

Address.....

Date signed.....

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Bacon

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 33

## CERTIFICATE OF DEATH

03525-35  
Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County..... Baltimore

City or town..... Baltimore - 14 (Conway)  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

2919 Joppa Road

How long in hospital or institution?

## 3. (a) FULL NAME

Charles Wesley Marsh

4. Sex male | 5. Color or race white | 6.(a) Single, married, widowed, or divorced widowed

6.(b) Name of husband or wife..... Emma E. Marsh

7. Birth date of deceased (mo., day, yr.) ..... June 9th, 1880 6.(c) If alive, give age years

8. AGE: Years 65 Months 10 Days 5 If less than one day hrs. min.

9. Birthplace..... Maryland (Town, county, and state)

10. Usual occupation..... retired

11. Industry or business

12. Name..... John Marsh

13. Birthplace..... England

14. Maiden name..... Margaret Knotts

15. Birthplace..... Maryland

16. Informant..... Mr. Charles T. Marsh

Address ..... 2900 Chenoweth Avenue

17. Burial ..... Date thereof..... 4/8/46  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Parkwood Cem.

Location ..... Baltimore

18. Funeral director..... Leonard J. Ruck

Address ..... 5305 Harford Road 14

19. 4/6 ..... 19. 46 ..... G.M. Bacon  
(Date rec'd by registrar) Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Baltimore

City or town..... Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No..... 2919 Joppa Road  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH ..... April 4th, 1946, at 2:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1, 1946, to April 4, 1946, and that I last saw h. m. alive on April 4, 1946.

Immediate cause of death.....

Hemiplegia, right

DURATION

4 days

Due to..... Infarction and cerebral meningitis

2 days

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE..... G.M. Bacon, M.D. .... M. D. or other

Address..... 2810 Taylor Ave. .... Date signed 4/6/46



I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 180

## CERTIFICATE OF DEATH

03526

Reg. Dist. No.

44

## 1. PLACE OF DEATH:

County

City or town

Baltimore

Chesaco Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

715 Chesaco Ave.

How long in hospital or institution?

## 3. (a) FULL NAME

Alice Roberta Matheny

## 3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

fm. white single

## 6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

June 28 - 1938

## 8. AGE:

Years

Months

Days

If less than one day

hrs. min.

7

10

## 9. Birthplace

Edgewater Md.

(Town, county, and state)

## 10. Usual occupation

-

## 11. Industry or business

-

## 12. Name

Ora Matheny

## 13. Birthplace

Va.

## 14. Maiden name

Lottie B. O. Daniel

## 15. Birthplace

N. C.

## 16. Informant

Ora L. Matheny

## Address

715 Chesaco Ave.

## 17. Burial

(Burial, cremation, or removal, which?)

Date thereof (month) (day) (year)

4/13/46

## Cemetery or crematory

Oak Lawn

## Location

Eastern Ave.

## 18. Funeral director

John G. Connally

## Address

418 Eastern Ave. Essex 21

## 19. (Date rec'd by registrar)

19. 4/13/46

19. 4/13/46

John G. Connally

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md.

County

Baltimore

City or town

Chesaco Park

Street No.

715 Chesaco Ave.

(If rural, give LOCATION)

## 2.(a) If veteran, name war

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

Apr 13 1946 at 11 P.M.

## 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Apr 13 1946 to

19.

and that I last saw her alive on

19.

## Immediate cause of death

Suffocation by smoke

DURATION

Due to 2<sup>o</sup> + 3<sup>o</sup> Burns over

Entire body.

Due to

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings or operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

At Home

Means of injury

Fire in home

injured at work?

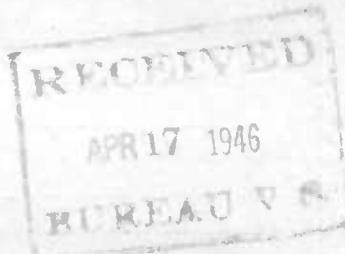
## 23. SIGNATURE

John G. Connally M.D. or other

Deputy medical examiner

Date signed

Donald J. Hobbs 4/13/46





# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03527

## CERTIFICATE OF DEATH

Reg. Dist. No. 49

44

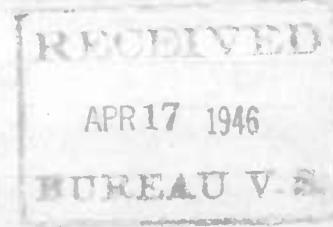
**PPLAINLY, WITH UNFADING INK.** Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VVS A15 0 47 15 N

1. PLACE OF DEATH: County..... <u>Baltimore</u> City or town..... <u>Chesaco Park</u> (If outside city or town limits, write RURAL and give nearest town)				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State..... <u>Md</u> County..... <u>Baltimore</u> City or town..... <u>Chesaco Park</u> (If outside city or town limits, write RURAL and give nearest town)			
How long in above place of death? Hospital, institution, or street address where death occurred: <u>715 Chesaco Ave.</u>				Street No. <u>715</u> Address <u>Chesaco Ave</u> (If rural, give LOCATION)			
How long in hospital or institution?				2. (a) If veteran, name war.			
3. (a) FULL NAME <u>Lorraine Marie Matheny</u>				3. (b) Social Security Number			
4. Sex <u>Female</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Single</u>			MEDICAL CERTIFICATION		
6. (b) Name of husband or wife —				20. DATE OF DEATH..... <u>April 12</u> 1946, at <u>11 AM</u>			
7. Birth date of deceased (mo., day, yr.) <u>Aug 6 - 1940</u>				21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>Apr 12 1946</u> , to <u>—</u> and that I last saw h.....alive on <u>—</u> 19..			
8. AGE:	Years <u>5</u>	Months	Days	If less than one day .....hrs. ....min.	Immediate cause of death <u>Suffocation by Smoke</u>		
9. Birthplace..... <u>Baltimore City</u> (Town, county, and state)				DURATION			
10. Usual occupation..... <u>—</u>				<u>683° Burning over</u>			
11. Industry or business				<u>extinct 8 days</u>			
12. Name..... <u>Ora Matheny</u>				Due to.....			
13. Birthplace..... <u>Va.</u>				Due to.....			
14. Maiden name..... <u>Lottie S. O. Daniel</u>				Other conditions			
15. Birthplace..... <u>N. C.</u>				(Include pregnancy within 3 months of death)			
16. Informant..... <u>Ora Z Matheny</u>				Major findings of operations			
Address..... <u>715 Chesaco Ave.</u>				Date of op.			
17. Burial..... <u>Burial</u> (Burial, cremation, or removal. Which?)				Autopsy results.			
Date thereof..... <u>4/13/46</u> (month) (day) (year)				PHYSICIAN: Please underline the cause to which death should be charged statistically.			
Cemetery or crematory..... <u>Oak Lawn</u> .				22. VIOLENCE: If death was due to external causes, fill in the following:			
Location..... <u>Eastern Ave.</u>				Accident, suicide, or homicide..... <u>accident</u> Date of..... <u>4/13/46</u>			
18. Funeral director..... <u>John G Connally</u>				Where did injury occur? <u>Chesaco Park Baltimore Md</u> (City or town) (County) (State)			
Address..... <u>418 Eastern Ave. Essex 21</u>				Injured at home, farm, industry, public place (where?) <u>At home</u>			
19. <u>4/13/46</u> 19. <u>46</u> John G Connally (Date rec'd by registrar)				Means of injury..... <u>Fire in home</u> Injured at work? <u>No</u>			
				23. SIGNATURE..... <u>John G Connally M.D.</u> Deputy medical examiner Address..... <u>418 Eastern Ave. Essex 21</u>			
				M.D. or other _____ Date signed <u>4/13/46</u>			



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARGIN RESERVED FOR BINDING

03528

**MARYLAND STATE**  
**HEALTH DEPARTMENT**  
**CERTIFICATE OF DEATH**

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Md (b) County Baltimore  
(c) City or town Parkville  
(If outside city or town limits, write RURAL and give town)

(d) Street No. 8326 Beaufort Ave  
(If rural, give location)

(e) Citizen of foreign country? No  
If yes, name country.

**3 (a) FULL NAME** Oscar H. McDorman

**3 (b) If veteran, name war**

**3 (c) Social Security Account**  
No. 217-08-3004

**4. Sex** M **5. Color or race** W **6 (a) Single, married, widowed, or divorced.** Married

**6 (b) Name of husband or wife** Nelton M.

**6 (c) If alive, give age years**

**7. Birth date of deceased (mo., day, yr.)** 5-10-95

**8. AGE:** Years 50 Months 11 Days 8 If less than one day  
hr.  min.

**9. Birthplace** Somerset Co. Md  
(Town, county, and state)

**10. Usual Occupation** Cashier American Store

**11. Industry or business** Grocery

**MOTHER FATHER**

**12. Name** E. Wright McDorman

**13. Birthplace** Md

**14. Maiden Name** Mary O'Dooley

**15. Birthplace** Md

**16 (a) Informant** Mrs. Nelton M. McDorman  
**(b) Address** 8326 Beaufort Ave

**17 (a) Burial** Burial **(b) Date thereof** 4-22-46  
(Burial, cremation, or removal) (month) (day) (year)

**(c) Cemetery or crematory** Baltimore National  
**Location** Baltimore Md

**18 (a) Funeral director** Leonard J. Pugh  
**(b) Address** 5305 Hanover Rd.

**19 (a) 4-20-46 (b) as above**  
(Date rec'd by registrar) per TV Registrar

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** April 18 1946 at 1:15 PM

**21. I certify that death occurred on the date above stated; that I attended deceased from 4/18/46 to 4/18 1946, and that I last saw him alive on 4/18 1946.**

**Immediate cause of death**

Coronary thrombosis

**Due to**

**Duration** 1 hour

**Other Conditions**

**(Include pregnancy within 3 months of death)**

**Date of operation**

**Major findings of operation**

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

**22. If death was due to external causes, fill in the following:**

**(a) Accident, suicide, or homicide**

**(b) Date of occurrence**

**(c) Where did injury occur?** (City or town) (County) (State)

**(d) Did injury occur about home, on farm, industrial place, in public place? While at work?** (Specify type of place)

**(e) Means of injury**

**23. Signature** H. E. Great M. D.  
**Address** 8100 Hanover Rd signed 4/19/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131-2

03529

## CERTIFICATE OF DEATH

Reg. Dist. No. 43

## 1. PLACE OF DEATH:

County..... Baltimore County  
 City or town..... Parkville (Balto 14)  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 4 yrs.  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Frances Elmira McIntire

## 3. (b) Social Security Number

none

4. Sex..... FEMALE 5. Color or race..... WHITE 6. (a) Single, married, widowed, or divorced..... WIDOWED

6. (b) Name of husband or wife..... SAM. JEFFERSON MCINTIRE7. Birth date of deceased (mo., day, yr.)..... July 12 - 1858 6. (c) If alive, give age..... dec. years8. AGE: Years..... 87 Months..... 9 Days..... 6 If less than one day..... 1 hrs..... 30 min.9. Birthplace..... Lower Oxford Twp. Chester Co.  
(Town, county, and state) Penna.10. Usual occupation..... Housewife

## 11. Industry or business

12. Name..... Franklin Johnson  
 MOTHER FATHER13. Birthplace..... Chester Co., Penna.14. Maiden name..... Mary Ann McClurg15. Birthplace..... Chester Co., Penna.

## 16. Informant

## Address

17. Burial..... Burial Date thereof..... Apr. 22 - '46  
(Burial, cremation, or removal. Which?)Cemetery or crematory..... Oxford Location..... Oxford, Chester Co Penna18. Funeral director..... Lazarus Funeral Home  
 Address..... 7401 Belair Rd19. Alex 18..... 1946 M.S.C.L. Rejander  
(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Baltimore Co.  
 City or town..... Parkville (Balto 14)  
(If outside city or town limits, write RURAL and give nearest town)  
 Street No..... 3009 Taylor Ave  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... April 18, 1946 at 1:30 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 5 1946, to April 18 1946 and that I last saw her..... alive on April 17, 1946.

## Immediate cause of death

Arteriosclerotic cardiovascular disease

Due to.....

Due to.....

## Other conditions

(Include pregnancy within 8 months of death)

## Major findings of operations

Date of op.....

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State)

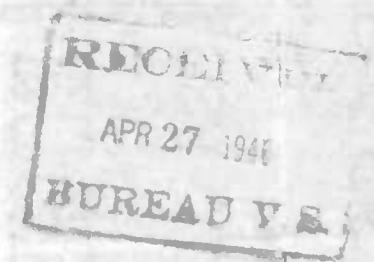
Injured at home, farm, industry, public place (where?)

## Means of injury

Injured at work?

## 23. SIGNATURE

Harold A. Grotz, M.D.  
 M. D. or other  
 Address..... 8100 Harford Rd. Date signed 4/18/46



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 22-2

## CERTIFICATE OF DEATH

0353032  
Reg. Dist. No.

**1. PLACE OF DEATH:**  
 County.....**Baltimore**  
 City or town.....**Mount Wilson**  
(If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?.....**0 yrs., 3 mos., 3 days**  
 Hospital, Institution, or street address where death occurred: **Mt. Wilson Branch, Md. Tuberculosis Sanatorium**  
 How long in hospital or institution?.....**0 yrs., 3 mos., 3 days**

**2. USUAL RESIDENCE (HOME) OF DECEASED:**  
(For newborn infants give residence of mother)  
 State.....**Maryland** County.....  
 City or town.....**Baltimore**  
(If outside city or town limits, write RURAL and give nearest town)  
 Street No.....**3212 W. Garrison Avenue**  
(If rural, give LOCATION)  
 2.(a) If veteran, name war.....

**3. (a) FULL NAME**  
**John McTaggart**

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced		
Male	White	Married		
8.(b) Name of husband or wife..... <b>Marie C. McTaggart</b>				
7. Birth date of deceased (mo., day, yr.)..... <b>March 13, 1896</b>				
6.(c) If alive, give age..... <b>52</b> years				
8. AGE:	Years	Months	Days	11 less than one day
	50	1	5	.....hrs. .....min.
9. Birthplace..... <b>New York, New York</b> <small>(Town, county, and state)</small>				
10. Usual occupation..... <b>Race Track Patrol Judge</b>				
11. Industry or business				
12. Name..... <b>Daniel McTaggart</b>				
13. Birthplace..... <b>Ireland</b>				
14. Maiden name..... <b>Marie McDonald</b>				
15. Birthplace..... <b>Vineland, New Jersey</b>				
16. Informant..... <b>Mrs. Marie V. Moeller</b>				
Address..... <b>3212 W. Garrison Ave., Balto. Md.</b>				
17. Burial..... <b>Burial</b>	Date thereof..... <b>April 20, 1946</b>			
(Burial, cremation, or removal. Which?)				
Cemetery or crematory..... <b>Druid Ridge Cemetery</b>				
Location..... <b>Reisterstown Rd., Maryland</b>				
18. Funeral director..... <b>Loring Byers</b>				
Address..... <b>5005 Park Heights Ave., Balto., Md.</b>				
19. April 18, 1946 <small>(Date rec'd by registrar)</small>	<i>Earl Webster</i>			

**3. (b) Social Security Number**  
 No. Unknown

**MEDICAL CERTIFICATION**

20. DATE OF DEATH	April 18,	1946	at 3:30 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 15, 1946, to April 18, 1946, and that I last saw him alive on April 18, 1946.			
Immediate cause of death	<u>General Miliary Tuberculosis</u>		
	DURATION 5 Mos.		
Due to	<u>Tubercle Bacilli</u>		
Due to			
Other conditions	<u>Tuberculous Epididymitis</u>		
(Include pregnancy within 3 months of death)			
Major findings or operations	<u>No operation</u>		
Date of op.			

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

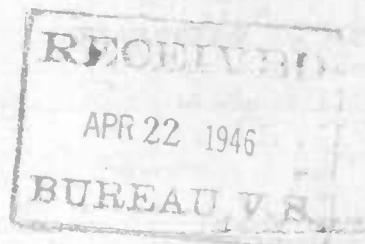
Means of injury..... Injured at work?

23. SIGNATURE..... *Stewart J. Shaffer M.D.*

M. D. or other

Address..... **Mount Wilson, Md.** Date signed **4/18/46**

*Recd 4 - 19-46 for E & Nichols*



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 45B

03531

Reg. Dist. No. 32

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH:

County.....Baltimore  
City or town.....Mount Wilson

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 yrs., 9 mos., 16 daysHospital, institution, or street address where death occurred: Mt. Wilson

Branch, Md. Tuberculosis Sanatorium

How long in hospital or institution? 15 yrs., 9 mos., 16 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....Maryland County.....BaltimoreCity or town.....Mount Wilson (If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

George H. Meekins

## 3. (b) Social Security Number

None4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) August 4, 1882 6.(c) If alive, give age..... years8. AGE: Years 63 Months 7 Days 30 If less than one day  
hrs. ..... min. ....9. Birthplace.....Maryland (Town, county, and state)10. Usual occupation.....None

11. Industry or business

MOTHER FATHER 12. Name.....William P. Meekins13. Birthplace Baltimore, Maryland14. Maiden name.....Anna H. Hild15. Birthplace Baltimore, Maryland16. Informant.....George H. MeekinsAddress Mount Wilson, Maryland17. Burial.....St. Mary's Star of The Sea Date thereof.....April 6, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Meekins' Point, MarylandLocation George T. Evans18. Funeral director.....118 W. Mt. Royal Ave., Balto., Md.Address Earl T. Webster

19. April 3, 1946 (Date rec'd by registrar)

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 3, 1946 1. 46, 1:20 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 18, 1946, to April 3, 1946,and that I last saw him alive on April 3, 1946.

Immediate cause of death

Coronary OcclusionNephritisDue to ArteriosclerosisHypertensionDue to Cancer of pillar of tonsilOther conditions Pulmonary Tuberculosis DURATION 24 yrs.

(Include pregnancy within 8 months of death)

Major findings of operations No operation Date of op.Autopsy results No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Stewart S. Shaffer M.D. M. D. or otherAddress Mount Wilson, Md. Date signed 4/3/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-2

## CERTIFICATE OF DEATH

03532

Reg. Dist. No. 41

## 1. PLACE OF DEATH

County.....*Baltimore*  
 City or town.....*Dundalk Maryland*  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

*Elizabeth Blanch Miller*

## 3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
<i>Female</i>	<i>White</i>	<i>Married</i>

<i>Frances C. Miller</i>
--------------------------

6. (c) If alive, give age *54* years7. Birth date of deceased (mo., day, yr.) *Nov. - 6 - 1891*

8. AGE: Years	Months	Days	It less than one day
<i>54</i>	<i>5</i>	<i>6</i>	hrs. min.

9. Birthplace *West Moreland Co. - Pa.*  
(Town, county, and state)

10. Usual occupation.

11. Industry or business *At Home*12. Name *William Dunnire*13. Birthplace *West Moreland Co. - Pa.*14. Maiden name *Sarah Gardner*15. Birthplace *West Moreland Co. - Pa*16. Informant *Francis C. Miller*Address *26 Liberty Parkway*17. Burial Date thereof *4/15/46*  
(Burial, cremation, or removal. Which?)Cemetery or crematory *Meadowridge Cem.*Location *Washington Blvd.*18. Funeral director *John C. Miller Inc.*Address *2435 E. Oliver Street*19. *4-15* 19...*46* *aw/ledysch*  
(Date rec'd by registrar)*per addy* Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....*Baltimore*  
 County.....*Baltimore*  
 City or town.....*Dundalk Maryland*  
(If outside city or town limits, write RURAL and give nearest town)  
 Street No.....*26 Liberty Parkway*  
(If rural, give LOCATION)

2.(a) If veteran, name war.

## MEDICAL CERTIFICATION

20. DATE OF DEATH *Apr 12* 19...*46* at *12:20 P.M.*21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *Mar. 1*, 19...*46* to *Apr 12*, 19...*46* and the last saw her alive on *Apr 12*, 19...*46*.Immediate cause of death *Myocarditis* DURATION *2 years*Due to *Arteriosclerotic heart disease* 22 yrs

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE *David H. Andrew Jr.* M. D. or otherAddress *2100 1/2 Moreland Rd.* Date signed *4/13/46*

## MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH  
County . . . . .  
Balto.

## 2. FULL NAME

JOHN A. MILLER

St. . . . .

Registration Dist. No. . . . .

Village or City . . . . .

Armacost Nursing Home

No. . . . .

St. . . . .

Ward . . . . .

Length of residence in city or town where death occurred . . . . . yrs. . . . . mos. . . . . ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number)

How long in U. S. if of foreign birth? . . . . . yrs. . . . . mos. . . . . ds.

## 3. SEX

Male

## 4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED,  
OR DIVORCED (write the word)

Married

# UNITED STATES STANDARD CERTIFICATE OF DEATH

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

**Statement of cause of death.**—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:

<i>Arteriosclerosis</i>	Date of onset 1915
<i>Chronic interstitial nephritis</i>	1921
<i>Cerebral hemorrhage</i>	July 5, 1927

Other contributory causes of importance:

<i>Gallstones</i>	Date of onset May 1, 1923

Example II

The principal cause of death and related causes of importance were as follows:

<i>Attack of epilepsy</i>	Date of onset 1 week ago
<i>Run over by street car</i>	1 week ago
<i>Peritonitis</i>	3 days ago

Other contributory causes of importance:

<i>Gastroenteritis</i>	Date of onset 1 year

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1242

03534

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

**I. PLACE OF DEATH:**  
 County..... Baltimore.  
 City or town..... Fort Howard.  
(If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 176 Days.  
 Hospital, institution, or street address where death occurred:  
Vets. Adm. Hosp., Ft. Howard, Maryland.  
 How long in hospital or institution? 176 Days.

**2. USUAL RESIDENCE (HOME) OF DECEASED:**  
(For newborn infants give residence of mother)

State..... Maryland. County.....  
 City or town..... Baltimore.  
(If outside city or town limits, write RURAL and give nearest town)  
 Street No..... 806. Stiles Street.  
(If rural, give LOCATION)  
 2.(a) If veteran, name war..... WW-I.

**3. (a) FULL NAME**JOSEPH MORISI**3. (b) Social Security Number**

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Single

B.(b) Name of husband or wife..... Single.

7. Birth date of deceased (mo., day, yr.) 8-27-94

8. AGE:	Years	Months	Days	If less than one day
	51	7	7	hrs. ..... min.

9. Birthplace..... Italy.  
(Town, county, and state)

10. Usual occupation..... Laborer.

## 11. Industry or business

12. Name..... Paul Morisi.

13. Birthplace..... Italy.

14. Maiden name..... Rose Poggioli.

15. Birthplace..... Italy.

16. Informant..... Clinical Records, Vets. Adm. Hosp.

Address..... Ft. Howard, Maryland.

17. Burial..... Burial. Date thereof..... April 8-1946  
(Burial, cremation, or removal. Which?)

Cemetery or crematory..... Baltimore National Cemetery.

Location..... Frederick Rd. Balt. Md.

18. Funeral director..... Frank Della Noce.

Address..... 52 W. Morley St.

19. Date rec'd by registrar..... Apr. 6 1946 A.W. Tocchini

Registrar..... G.F.A.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH..... April 4, 1946, at 6:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 10, 1945, to April 4, 1946, and that I last saw him alive on April 4, 1946.

Immediate cause of death..... Cirrhosis of liver.

Due to..... Chronic Alcoholism.

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

Signature..... Robert M. Cullison

R.M. Cullison, M.D. Act. Clin. Director

Address..... Ft. Howard, Maryland. Date signed 4-5-46

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 925

## CERTIFICATE OF DEATH

03535

Reg. Dist. No. 31

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:  
 County Baltimore County  
 City or town Woodlawn  
(If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 29 years  
 Hospital, institution, or street address where death occurred: 1932 Summit Avenue  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
 State Maryland County Baltimore Co.  
 City or town Woodlawn  
(If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1932 Summit Ave  
(If rural, give LOCATION)  
 2.(a) If veteran, name war None

3. (a) FULL NAME Ida Goldie Myers

3. (b) Social Security Number

4. Sex	5. Color or race	6.(n) Single, married, widowed, or divorced
<u>Female</u>	<u>White</u>	<u>Married</u>

6.(b) Name of husband or wife Mr. Ira B. Myers

7. Birth date of deceased (mo., day, yr.) Sept 28 1880

8. AGE: Years 65 Months 6 Days 12 If less than one day  
 hrs. ..... min.

9. Birthplace Carroll Co Maryland  
(Town, county, and state)

10. Usual occupation House keeper

11. Industry or business Own home

12. Name Frank Fowle

13. Birthplace Baltimore Co Maryland

14. Maiden name Martha Jackson

15. Birthplace Carroll Co Maryland

16. Informant Mrs. Ernest Myers

Address 3420 Lyndale Ave

17. Burial Date thereof 4/13/46  
(Burial, cremation, or removal. Which?)

Cemetery or crematory Pleasant Grove Cem.

Location Balto. Co., Md.

18. Funeral director W.M. J. TICKNER & SONS

Address Balto., Md.

19. 4/11 1946 A.W. Hedrick  
(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 10 1946 at 3 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1 1933 to April 10 1946 and that I last saw her alive on April 8 1946.

Immediate cause of death Chronic Myocardial Degeneration DURATION 11 years

Due to:

Due to: Mitral Regurgitation (Heart) 1 yr

Other conditions Arterial hypertension 12 years

(Include pregnancy within 3 months of death)

Major findings or operations No operation Date of op.

Autopsy results No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Joshua H. Armacost M. D. or other M.D.

Address 6419 Windsor Mill Road signed April 10, 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 33

03536

35

## CERTIFICATE OF DEATH

Reg. Dist. No.

## 1. PLACE OF DEATH:

County BALTIMORECity or town WHITE HALL

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 1/2 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

CLIFFORD LE Roy NELSON

## 3. (b) Social Security Number

NONE4. Sex MALE 5. Color or race WHITE 6.(a) Single, married, widowed, or divorced MARRIED6.(b) Name of husband or wife GEORGIA A NELSON7. Birth date of deceased (mo. day. yr.) Nov. 8 1886 8.(c) If alive, give age 60 years8. AGE: Years 59 Months 5 Days 14 If less than one day hrs. \_\_\_\_ min. \_\_\_\_9. Birthplace HARFORD Co. MD  
(Town, county, and state)10. Usual occupation MERCHANT

## 11. Industry or business

12. Name NICHOLAS NELSON13. Birthplace HARFORD Co. MD14. Maiden name LOVELLA LUCKEY15. Birthplace HARFORD Co. MD16. Informant MRS. GEORGIA A NELSONAddress WHITE HALL MD17. BURIAL Date thereof APRIL 14 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory BETHELLocation WHITE HALL R.F.D. MD18. Funeral director Howard S. MarklineAddress White Hall Md19. Apr. 23, 1946 Mrs. Howard S. Markline  
(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County BALTIMORECity or town WHITE HALL  
(If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_

(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH APRIL 22 1946 at 6:30 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2 May 1945 to April 22 1946 and that I last saw him alive on April 21, 1946.

Immediate cause of death

Aprophy

DURATION

5 daysDue to Hypertension3 yrs

Due to \_\_\_\_\_

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op. \_\_\_\_\_

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury

Injured at work?

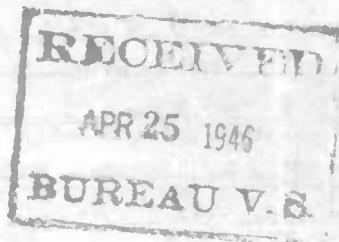
23. SIGNATURE Mabel Porter Jr. D.

M. D. or other

Address White HallDate signed Apr 23, 1946

STAMP TO IDENTIFY THE STATE OF MICHIGAN

RECEIVED BY TELETYPE



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

## CERTIFICATE OF DEATH

Reg. Dist. No. 03537

1. PLACE OF DEATH:  
County..... **Baltimore**  
City or town..... **Pikesville**  
(If outside city or town limits, write RURAL and give nearest town)  
**7 yrs**  
How long in above place of death?  
Hospital, institution, or street address where death occurred:  
**Augsburg Home Campfield Rd.**  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State..... **Md.** County..... **Baltimore**  
City or town..... **Pikesville**  
(If outside city or town limits, write RURAL and give nearest town)  
Street No..... **Campfield Rd.**  
(If rural, give LOCATION)

## 3. (a) FULL NAME

**Edith Nicholson**

## 3. (b) Social Security Number

4. Sex <b>F.</b>	5. Color or race <b>W</b>	6. (a) Single, married, widowed, or divorced <b>Widow</b>
---------------------	------------------------------	--

6. (b) Name of husband or wife..... **Edgar E.**  
6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)  
**May 21 1864**

8. AGE: Years <b>81</b>	Months <b>10</b>	Days <b>17</b>	If less than one day ..... hrs. ..... min.
----------------------------	---------------------	-------------------	---

9. Birthplace..... **Woodlawn Md.**  
(Town, county, and state)  
None

10. Usual occupation.....

11. Industry or business  
FATHER..... **John P. Heacock**

MOTHER..... **Catonsville**  
12. Name..... **Hannah Haitley**

13. Birthplace..... **Quaker Hill Md.**  
14. Maiden name.....

15. Birthplace..... **Mr. Theo. Katenkamp**  
16. Informant.....

Address..... **Campfield Rd. Pikesville P.O.**

17. Burial..... Date thereof..... **April 11 46**  
(Burial, cremation, or removal. Which?)  
Cemetery or crematory..... **Mt. Olive Oak Crt. Rd.**

Location..... **Randalstown**  
18. Funeral director..... **L. Heemann and Son**

Address..... **32 S. Broadway**

19. **4/8/46** 1946 **Tom E. Martin**  
(Date rec'd by registrar) **Registrar**

## MEDICAL CERTIFICATION

April 8 1946 at 5:00 M

20. DATE OF DEATH.....  
1946 to April 8, 1946  
and that I last saw her alive on April 6, 1946

Immediate cause of death.....  
**Coronary occlusion**

DURATION  
1/2

Due to.....

Due to.....

Other conditions.....  
(Include pregnancy within 3 months of death)

Major findings of operations.....  
Date of op.

Autopsy results.....  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide..... Date of.....

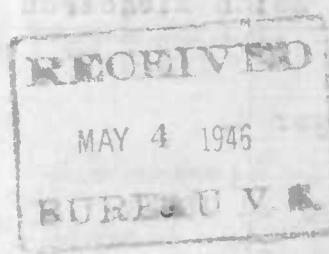
Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... **Tom E. Martin** M. D. or other

Address..... **Randalstown Md.** Date signed **4/8/46**



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 33-2

## CERTIFICATE OF DEATH

03538

+4

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## 1. PLACE OF DEATH:

County..... Baltimore

City or town..... Fort Howard

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 20 Days

Hospital, institution, or street address where death occurred:

Vets. Adm. Hosp., Ft. Howard, Maryland

How long in hospital or institution?..... 20 Days

## 3. (a) FULL NAME

HARRY NICKENS

4. Sex..... 5. Color or race..... 6.(a) Single, married, widowed, or divorced

Male Colored Married

8.(b) Name of husband or wife..... Mrs. Jennie Nickens

7. Birth date of deceased (mo., day, yr.)..... 6.(c) If alive, give age..... 44 years

8. AGE: Years Months Days If less than one day  
57 4 2 hrs. min.9. Birthplace..... New Orleans, La.  
(Town, county, and state)

10. Usual occupation..... Minister

## 11. Industry or business

12. Name..... Unknown

13. Birthplace..... "

14. Maiden name..... Unknown

15. Birthplace..... "

16. Informant..... Clinical Records, Vets. Adm. Hosp.

Address..... Ft. Howard, Maryland

17. Burial..... Date thereof..... 5-1-46  
(Burial, cremation, or removal? Which?) Date thereof..... (month) (day) (year)

Cemetery or crematory..... Phila. Pa.

Location..... Phila. Pa.

18. Funeral director..... Charles R. Law

Address..... 802 Madison St., Balto., Md.

19. (To be filled by registrar) 4-29-46 *Surferd* Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County.....

City or town..... Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 701 North Carey Street

(If rural, give LOCATION)

2.(a) If veteran, name war..... WW-I

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... April 26, 1946, at 11:10 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April 6, 1946, to April 26, 1946, and that I last saw him alive on April 26, 1946.

## Immediate cause of death

Carcinomatosis, generalized.

DURATION

Unknown

## Due to

Primary site of carcinoma, unknown.

Cause of death

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op.

Autopsy results..... Substantiated above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... Robert M. Cullison, M.D. CLIN. D. Father

Address..... Ft. Howard, Md.

Date signed..... 4-27-46

## MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (B)

Reg. Dist. No. 43534

## CERTIFICATE OF DEATH

1. PLACE OF DEATH:  
 (a) County Baltimore  
 (b) City or town Essex (Baltimore 21)  
 (c) Street address, hospital, or institution:  
325 N Marlyn Ave  
 (d) Length of stay in hospital or inst. (yrs., mos., or days)  
 (e) Length of stay in this community (yrs., mos., or days)

2. HOME (USUAL RESIDENCE) OF DECEASED:  
 (a) State Maryland (b) County Baltimore  
 (c) City or town ESSEX  
 (d) Street No. 325 N Marlyn Ave  
 (e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years

3 (a) FULL NAME Henry Norris

3 (b) If veteran, name war

3 (c) Social Security

No. None

4. Sex <u>Male</u>	5. Color or race <u>White</u>	6 (a) Single, married, widowed, or divorced. <u>Widower</u>
-----------------------	----------------------------------	--

6 (b) Name of husband or wife Emma Norris

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/1/1860

8. AGE: Years <u>86</u>	Months <u>1</u>	Days <u>26</u>	If less than one day hr. _____ min.
----------------------------	--------------------	-------------------	--

9. Birthplace Baltimore County Md.  
(Town, county, and state)10. Usual occupation Truck farmer

11. Industry or business

12. Name J. Norris13. Birthplace Germany14. Maiden Name Unknown15. Birthplace Germany16 (a) Informant Mrs. Stefan Rothermel  
(b) Address 325 N Marlyn Ave17 (a) Burial Burial (b) Date thereof 4/30/46  
(Burial, cremation, or removal)  
(c) Cemetery or crematory Oak Lawn18 (a) Funeral director Tassau Funeral Home  
(b) Address 7401 Belair Road19 (a) 44-29-46 (b) John A. Connally  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. Date of death april 27 1946, at 9 A M21. I certify that death occurred on the date above stated; that I attended deceased from april 1 1946, to april 27 1946, and that I last saw him alive on april 27 1946.Immediate cause of death ObesityThrombosis

Duration

IndefiniteDue to Arterio-Adiposity  
cardio-vascular disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide
- (b) Date of occurrence
- (c) Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)
- (d) Did injury occur about home, on farm, industrial place, in public place? \_\_\_\_\_ While at work?  
(Specify type of place)

(e) Means of injury

23. Signature J. W. Baumgardner  
M. D. or otherAddress Baltimore Date signed 4-27-46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. To correct age  
is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 470

03540

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

## 1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 Days

Hospital, Institution, or street address where death occurred:

Vets. Adm. Hosp., Ft. Howard, Maryland

How long in hospital or institution? 5 Days

## 3. (a) FULL NAME

PETER P. NOWAKOWSKI

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Male White Married

6.(b) Name of husband or wife Mrs. Grace Nowakowski

6.(c) If alive, give age 55 years  
7. Birth date of deceased (mo., day, yr.) 6-5-918. AGE: Years Months Days If less than one day  
54 10 8 hrs. min.9. Birthplace Baltimore, Maryland  
(Town, county, and state)

10. Usual occupation Unemployed

## 11. Industry or business

MOTHER FATHER 12. Name Steven Nowakowski

13. Birthplace Poland

14. Maiden name Mary Lorek

15. Birthplace Poland

16. Informant Clinical Records, Vets. Adm. Hosp.  
Address Ft. Howard, Maryland17. Burial Date thereof April 17, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory Baltimore National Cemetery

Location Baltimore, Maryland

18. Funeral director M. J. Sadowski &amp; Sons

Address 1808 Eastern Avenue

19. Date of registrar X/15/46 19 X 6 Registrant D.L. Hedrick  
Date of registrant D.L. Hedrick

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1903 West Lanvale Street

(If rural, give LOCATION)

2.(a) If veteran, name war WW-I

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH 4/13/46 19 46 at 16:50 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 8, 1946, to April 13, 1946,

and that I last saw him alive on April 13, 1946.

## Immediate cause of death

Bronchogenic carcinoma with metastasis to the ribs and bones

xxx of the pelvis.

DURATION

Unknown

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?  
Robt M. Cullison

23. SIGNATURE ROBERT M. CULLISON, M.D.

M. D. or other

Address Fort Howard, Maryland Date signed 4/13/46

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *Loa*

03541 P

## CERTIFICATE OF DEATH

Reg. Dist. No. *44*

## 1. PLACE OF DEATH:

County: BaltimoreCity or town: Ft. Howard

(If outside city or town limits, write RURAL and give nearest town)

12 days

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Vets. Adm. Hosp., Ft. Howard, Maryland

How long in hospital or institution?

12 days

## 3. (a) FULL NAME

PAUL A. PILOTE

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

MaleWhiteWidowed6.(b) Name of husband or wife Widowed

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.)

12-11-02

8. AGE:

Years  
43Months  
4Days  
10

If less than one day

hrs. .... min.

9. Birthplace

Illinois

(Town, county, and state)

10. Usual occupation

Mechanic

11. Industry or business

12. Name John Pilette13. Birthplace Illinois14. Maiden name Mary Beese15. Birthplace Illinois16. Informant Clinical Records, Vets. Adm. Hosp.Address Ft. Howard, Maryland

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof (month) (day) (year)

Cemetery or crematory Ft. Howard CemeteryLocation Ft. Howard Cemetery18. Funeral director A. Leo OderAddress 4644 York Road., Balt., Md.19. 4-2219. 46Aug. 2000  
Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland

County

City or town: Baltimore & Dundalk, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 6529 Fernell

(If rural, give LOCATION)

2.(a) If veteran, name war WW-2

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 21,1946 at 00 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 21, 1946, to 4-21- 1946and that I last saw h. im alive on April 21, 1946.

19...

Immediate cause of death

Acute Miliary Tuberculosis

DURATION

8 Wks.  
plus

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

Robert M. Cullison  
R.M.CULLISON, MD., ACTING CHIN. DIRT

Address

Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

## CERTIFICATE OF DEATH

03542  
Reg. Dist. No. ....

P

## 1. PLACE OF DEATH:

County ..... Balto. ....  
 City or town ..... Pikesville .....  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:  
7000 Alden Rd. ....

How long in hospital or institution?

## 3. (a) FULL NAME

BARBARA PISTEL

## 4. Sex

5. Color or race

Female White

6.(a) Single, married, widowed, or divorced

Widow

6.(b) Name of husband or wife..... William E. Pistel

7. Birth date of deceased (mo., day, yr.) Oct. 24, 1874

6.(c) If alive, give age years

8. AGE: Years Months Days If less than one day  
71 5 7 hrs. min.9. Birthplace ..... Baltimore, Md. ....  
(Town, county, and state)

10. Usual occupation ..... None

## 11. Industry or business

12. Name ..... John Eckstein

13. Birthplace ..... Germany

14. Maiden name ..... Catherine Urban

15. Birthplace ..... Germany

16. Informant ..... Mrs. Edna M. Schaeffer

Address ..... 7000 Alden Road, Pikesville

17. Burial ..... Date thereof ..... 4/4/46  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory ..... Loudon Park Cem.

Location ..... Balto., Md.

18. Funeral director ..... WM. J. TICKNER &amp; SONS

Address ..... Balto., Md.

19. 4-3 K6 Date rec'd by registrar ..... 15. *Dear Helen*  
*Registrar*

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State ..... Md. .... County ..... Baltimore .....  
 City or town ..... Pikesville .....  
(If outside city or town limits, write RURAL and give nearest town)  
 Street No. ..... 7000 Alden Road .....  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH ..... April 1, 1946, at 7:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
March 13, 1946, to April 1, 1946,  
and that I last saw her alive on April 1, 1946.

Immediate cause of death

*Heart failure*Due to ..... *coronary thrombosis*Due to ..... *arteriosclerosis*Other conditions ..... *Gingivitis, Rheumatoid Arthritis*

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. ....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work? *Yes*23. SIGNATURE ..... *Louis J. Urban, M.D.*

M. D. or other

Address ..... 1413 Restaurant Rd., Pikesville 8, Md.

Date signed ..... April 1/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 164-43

03543

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

County - Balt.

City or town - Daniels

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Jesse W. Porter

4. Sex

m

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Eleanor M. Porter

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age years

1878

8. AGE:

68

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

Unknown

12. Name

Mother Father

13. Birthplace

"

14. Maiden name

"

15. Birthplace

"

16. Informant

Roy Smith

Address

Bella Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof (month) (day) (year)

4-25-46

Cemetery or crematory

Bethany

Location

Towson Md.

70 Big Woods

18. Funeral director

Ellis J. City Md.

Address

Harold Miller

19. 4-22

Date rec'd by registrar

1946

Date signed

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State - Maryland County - Balt.

City or town - Daniels

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

213-09-6050

## MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 22 1946 at 3:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Apr 22 1946 to 1946  
and that I last saw him alive on Apr 22 1946

Immediate cause of death

Suicide - Gun shot wound  
Fractures of skull

DURATION

Instant

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

None

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Suicide Date of Apr 22 '46

Where did injury occur? Daniels Balt. Md.

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

None

Means of injury Gun shot

Injured at work? No.

23. SIGNATURE D. D. Caples, M.D.

M. D. or other Address Reisterstown, Md. Date signed Apr 22 '46



I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-2

## CERTIFICATE OF DEATH

03544

P

Reg. Dist. No. 42

1. PLACE OF DEATH:  
County.....  
City or town.....  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 4-19-44  
Hospital, institution, or street address where death occurred:  
Relay Sanitarium  
How long in hospital or institution?..... 4-19-44

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State..... Pa..... County..... Montgomery Co.  
City or town..... Gwynedd Valley  
(If outside city or town limits, write RURAL and give nearest town)

Street No.....  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME  
Poultnay, Eugene

4. Sex Male	5. Color or race white	6.(a) Single, married, widowed, or divorced widowed	
<i>Ella Patterson Poultnay</i>			
6.(b) Name of husband or wife.....		(b) If alive, give age..... years	
7. Birth date of deceased (mo. day, yr.) Jan. 27 1873		Oct 23 1871	
8. AGE: Years 74	Months 7	Days 10	If less than one day hrs. .... min.
9. Birthplace..... Baltimore, Md. (Town, county, and state)			
10. Usual occupation..... Real Estate Business			
11. Industry or business			
MOTHER FATHER	12. Name.....	S. Eugene Poultnay	
	13. Birthplace.....	Baltimore, Md.	
MOTHER	14. Maiden name.....	Lela L. Minis	
	15. Birthplace.....	Georgia	
16. Informant..... Brother - E. Curzon Poultnay			
Address..... Gwynedd Valley, Montgomery Co., Pa.			
17. Burial (Burial, cremation, or removal. Which?) Cemetery or crematory.....	Date thereof..... (month) (day) (year) Apr 5 1946	Date of op.....	
Location..... 18. Funeral director..... Address.....	Autopsy results..... PHYSICIAN: Please underline the cause to which death should be charged statistically.		
19. (Date rec'd by registrar)..... 4-4-46	22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide..... Date of.....		

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH..... April 2 1946 at 10:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
Jan 15 1946 to April 2 1946  
and that I last saw him alive on April 2 1946

Immediate cause of death.....  
*Cerebral hemorrhage*

Due to.....  
*Hypertension heart disease*

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....  
(City or town)..... (County)..... (State).....

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

3. SIGNATURE..... Luis P. Jenkins M.D.

M.D. or other

Address..... Date signed..... July 23, 1946 4/3/46

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-21

03545

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

## 1. PLACE OF DEATH:

Baltimore  
County.....

City or town..... Raspeburg (Baltimore 6 )

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Trump Mill Road Box 318

How long in hospital or institution?

## 3. (a) FULL NAME

Samuel D Prescoe

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male

Colored

Married

6.(b) Name of husband or wife..... Harriet Prescoe

7. Birth date of deceased (mo., day, yr.) ..... 9/21/1868

6.(c) If alive, give age ..... years

8. AGE:

Years

Months

Days

If less than one day

77

6

26

hrs.

min.

9. Birthplace..... Baltimore County, Md.

(Town, county, and state)

10. Usual occupation..... Farm Hand

## 11. Industry or business

12. Name..... Henry Prescoe

13. Birthplace..... Baltimore County

14. Maiden name..... Unknown

15. Birthplace.....

16. Informant..... Mrs Samuel D Prescoe

Address

Trump Mill Road

17. Burial

(Burial, cremation, or removal. Which?) Date thereof..... 4/18/46

(month) (day) (year)

Cemetery or crematory..... Putty Hill M E Cemetery

Location..... Putty Hill Md

18. Funeral director..... Lazarus Funeral Home

Address..... 7401 Belair Road

19. (Date rec'd by Registrar) ..... 4/17/46

19. (Date rec'd by Registrar) ..... 4/17/46

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County.....

City or town..... As in No 1

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) Is veteran, name war..... No

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... 4/16/46 8:10 AM 1946 at 8:10 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1 1946 to April 16 1946 and that I last saw him alive on April 16 1946.

Immediate cause of death..... Cerebral apoplexy

DURATION

Due to..... arterio-sclerotic condition

Vascular disease

Sudden

Due to.....

Other conditions.....

Gout

(Include pregnancy within 8 months of death)

Major findings or operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury.....

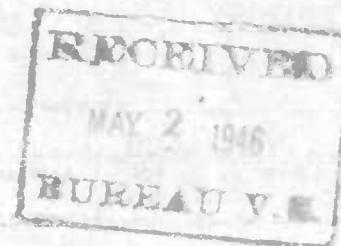
Injured at work? .....

23. SIGNATURE.....

M. D. or other

Address..... Baltimore Date signed..... 4-17-46

Dr Baumgartner



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 77

03546

Reg. Dist. No.

33

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH:

County

Baltimore

City or town

Upperville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

93 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

John Wesley Price

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male white Unknown.

6. (b) Name of husband or wife

Erminda J. Darr

7. Birth date of deceased (mo., day, yr.)

July 24 1848

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

97

9

5

hrs.

min.

9. Birthplace

Ellicott City Md

(Town, county, and state)

10. Usual occupation

Retail Farmer.

11. Industry or business

Agriculture

12. Name

John Price

13. Birthplace

Upperville Md.

14. Maiden name

W. unknown

15. Birthplace

Upperville Md.

16. Informant

Mrs. Rachel V. Gell

Address

Upperville Md.

17. Burial

Burial

Date thereof (month) (day) (year)

(Burial, cremation, or removal. Which?)

Pleasant Grove

Cemetery or crematory

Balto. Co.

Location

J. P. Eline &amp; Sons

18. Funeral director

Rustertown Md.

Address

19. 4 - 30

1946

(Date rec'd by registrar)

D. A. B. Eline

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md.

County

Baltimore

City or town

Upperville

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

April 29 1946 at 12:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 27, 1946 to April 29, 1946

and that I last saw him alive on April 27, 1946

Immediate cause of death

Dysentery of Liver

Staphylococcus

Due to

Sex Cut. Oclousus

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Edgar M. Bush, M.D.

M. D. or other

7 Hanoverfield Md. Date signed 4/29/46

RECEIVED

MAY 2 1946

BUREAU U.S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(BHD)

## CERTIFICATE OF DEATH

03548

Reg. Dist. No.

37

## 1. PLACE OF DEATH:

County BaltimoreCity or town Texas

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Baltimore County HomeStay in hospital or Inst. (yrs., or mos., or days) 5 yr. 8 mo. 1 daStay in this community (yrs., or mos., or days) 5 yr. 8 mo. 1 da

## 3. (a) FULL NAME

Nicholas Riege4. Sex M. 5. Color or race W 6.(a) Single, married, widowed, or divorced -6 (b) Name of husband or wife Augustig Blinoff6(c) If alive, give age - years

7. Birth date of deceased (mo., day, yr.)

Sept. 24, 18768. AGE: Years 69 Months 7 Days 4 If less than one dayhrs. - min. -9. Birthplace Germany  
(Town, county, and state)10. Usual occupation Farm Laborer

## 11. Industry or business

12. Name ? Riege13. Birthplace Germany14. Maiden name Anna Strunk15. Birthplace Germany16. Informant Mrs. A. NickelAddress 7011 Railway Ave Balt. Md.17. Burial Date thereof 5/1/46  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Baltimore County HomeLocation Texas Md.18. Funeral director John C. ConnallyAddress 415 Eastern Ave. Essex Md.19. 4/28 1946 Way J. Shilcock  
(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Essex Ward No.  
(If outside city or town limits, write RURAL NEAR and give town)Street No. -

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

2D. DATE OF DEATH April 28 1946, at 3:55 P.M.2E. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 10 1940, to Apr 28 1946, and that I last saw him - alive on 4/26, 1946.Immediate cause of death Chronic Influenza  
(Coma) DURATION 3 mo.Due to Arterio sclerosis5 yrs.Due to Sensitity

## Other conditions

(Include pregnancy within 8 months of death)

## Major findings:

Of operations

## Dt autopsy

## 22. VIOLENCE: If death was due to external causes, fill in the following:

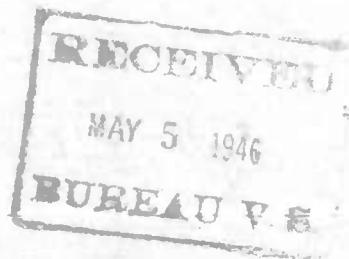
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE Wilmer C. Enser M.D. M. D. or otherAddress Cockeysville Md Date signed 4/28/46



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *(Handwritten)*

03549

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

Baltimore  
County.....  
Catonsville  
City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 23 yrs., 4 mos., 1 day

Hospital, institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 23 yrs., 4 mos., 1 day

## 3. (a) FULL NAME

Stephen Ronek

## 3. (b) Social Security Number

4. Sex      5. Color or race      6.(a) Single, married, widowed, or divorced  
male      white      single

6.(b) Name of husband or wife..... -

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years      Months      Days      If less than one day  
67      ?      ?      hrs.      min.9. Birthplace Germany  
(Town, county, and state)

10. Usual occupation Baker

11. Industry or business Baking

12. Name ?

13. Birthplace ?

14. Maiden name ?

15. Birthplace ?

16. Informant Hospital records  
Address Catonsville-28, Md.17. Burial Date thereof May 3, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Spring Grove State Hospital  
Location Catonsville 28, Maryland18. Funeral director Spring Grove State Hospital  
Address Catonsville 28, Maryland19. *5-4* ~ 1946 Harryell Miller  
(Date rec'd by registrar) Deputy Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County.....

City or town At large  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 12 1946 at 6:05 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 11 1922 to April 12 1946

and that I last saw him alive on April 12 1946

Immediate cause of death

DURATION

Carcinoma of the rectum

Indefinite

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results As above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

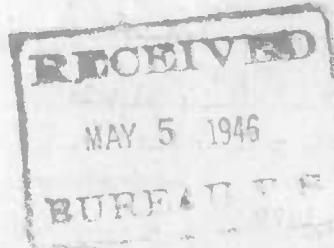
Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

*Isadore Tuerk*  
Isadore Tuerk, M.D.

M. D. or other

Address Catonsville-28, Md. Date signed 4-12-46



**PLEASE WRITE PLAINLY, WITH UNFADING INK.** Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 9<sup>th</sup>

03550

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

**1. PLACE OF DEATH:** Baltimore  
 County Baltimore  
 City or town Catonsville  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 yrs.

Hospital, institution, or street address where death occurred: Johnnycake Rd near Ingleside ave

How long in hospital or institution? \_\_\_\_\_

**3. (a) FULL NAME** Emily Buff

**4. Sex** F **5. Color of race** W. **6. (a) Single, married, widowed, or divorced** Single

**6. (b) Name of husband or wife** Late Louis G. Buff

**7. Birth date of deceased (mo., day, yr.)** **6. (c) If alive, give age** years

**8. AGE:** **Years** 18 **Months**  **Days**  **If less than one day**   
 hrs.  min.

**9. Birthplace** England  
(Town, county, and state)

**10. Usual occupation**

**11. Industry or business**

**12. Name**

**13. Birthplace**

**14. Maiden name**

**15. Birthplace**

**16. Informant** Mrs Virginia Cole

**Address** Johnnycake + Ingleside Road

**Burial** Cemetery **Date thereof** Apr. 22/46.  
(Burial, cremation, or removal, Which) **(month) (day) (year)**

**Cemetery or crematory** New Cathedral

**Location** 4300 Old Frederick Rd.

**18. Funeral director** Harry H. Miller

**Address** 4101 Edmondson Ave

**19. Date rec'd by registrar** 4-20-46 **Registrar** Harry H. Miller  
(Date rec'd by registrar)

**2. USUAL RESIDENCE (HOME) OF DECEASED:**  
(For newborn infants give residence of mother)

State Md. County Baltimore  
 City or town Catonsville  
If outside city or town limits, write RURAL and give nearest town)

Street Next Johnnycake Rd near Ingleside  
If rural, give LOCATION)

**2.(a) If veteran, same war** \_\_\_\_\_

**3. (b) Social Security Number** \_\_\_\_\_

### MEDICAL CERTIFICATION

**20. DATE OF DEATH** 4/18/46 **19** 34 **M**

**21. I CERTIFY that death occurred on the date above stated: That I attended deceased from Saw **19** 14 **to** April 18 **19** 46, and that I last saw her alive on April 18 **19** 46.**

**Immediate cause of death** Coronary heart disease **DURATION** 1 month

**Due to** Arteriosclerosis **7**

**Due to** \_\_\_\_\_

**Other conditions** \_\_\_\_\_

**(Include pregnancy within 8 months of death)** \_\_\_\_\_

**Major findings of operations** \_\_\_\_\_ **Date of op.** \_\_\_\_\_

**Autopsy results** \_\_\_\_\_

**PHYSICIAN: Please underline the cause to which death should be charged statistically.** \_\_\_\_\_

**22. VIOLENCE:** If death was due to external causes, fill in the following:

**Accident, suicide, or homicide** \_\_\_\_\_ **Date of** \_\_\_\_\_

**Where did injury occur?** \_\_\_\_\_ **(City or town)** \_\_\_\_\_ **(County)** \_\_\_\_\_ **(State)** \_\_\_\_\_

**Injured at home, farm, industry, public place (where?)** \_\_\_\_\_

**Means of injury** \_\_\_\_\_ **Injured at work?** \_\_\_\_\_

**23. SIGNATURE** Jean A. Korthman, M.D. **M. D. or other** \_\_\_\_\_

**Address** Delaware **Date signed** 4/19/46



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

## CERTIFICATE OF DEATH

03551 J4  
Reg. Dist. No.

## 1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

6 yr.

Hospital, institution, or street address where death occurred:

6800 Coronary.

How long in hospital or institution?

## 3. (a) FULL NAME

EMERY PLATT RULAND.

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

M. W. Married.

6. (b) Name of husband or wife

Mildred - Kennedy

6. (c) If alive, give age 36 years

7. Birth date of deceased (mo., day, yr.)

January 2 1904

8. AGE:

Years Months Days If less than one day  
42 3 9 . hrs. . min.

9. Birthplace

Agusta - Georgia  
(Town, county, and state)

10. Usual occupation

Wardresser DRM - 98

11. Industry or business

Bethel Steel Corp.

12. Name

Emery P. Ruland

13. Birthplace

Flushing L.C.

14. Maiden name

Lila Benson

15. Birthplace

Agusta Ga.

16. Informant

Mrs. Mildred Ruland

Address

6800 Coronary, Dundalk

17. Burial, cremation, or removal

Magnolia Cem. Date thereof 4/12/46  
(Which?) (month) (day) (year)

Cemetery or crematory

Magnolia

Location

Augusta Ga.

18. Funeral director

John G. Connally

Address

418 Eastern Ave. Edgewood

19. (Date rec'd by registrar)

April 12 1946 John G. Connally

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No. 6800

Coronary.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

216-18-7543

## MEDICAL CERTIFICATION

20. DATE OF DEATH

April 11 1946 a.m. 2<sup>nd</sup> M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19... fo.

19.

and that I last saw h. alive on

19.

Immediate cause of death

Coronary Occlusion 2 hrs.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

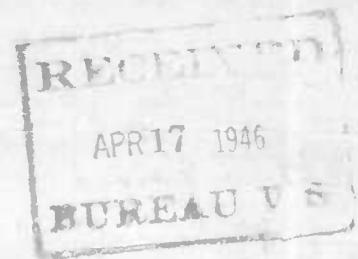
Means of injury

Injured at work?

23. SIGNATURE

M.B. Davis M.D. for others

Address 101 E. Pratt St. Baltimore, Md. Date signed April 12, 1946



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

03552

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNTANDING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## 1. PLACE OF DEATH:

County.....  
Baltimore  
Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 42 years, 5 months, 2 days

Hospital, institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution?..... 42 years, 5 months, 2 days

## 3. (a) FULL NAME

Elizabeth Russel

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife..... unknown

7. Birth date of deceased (mo., day, yr.)..... 1863

8. AGE:	Years	Months	Days	If less than one day
	83	?	?	hrs. .... min.

9. Birthplace..... Virginia  
(Town, county, and state)

10. Usual occupation..... unknown

11. Industry or business..... unknown

MOTHER FATHER  
12. Name..... unknown

13. Birthplace..... unknown

14. Maiden name..... unknown

15. Birthplace..... unknown

## 16. Informant..... Hospital Records

Address..... Catonsville 28, Md.

17. Burial..... Date thereof..... 4/11/46  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory..... Mt. Olive Cem

Location..... Randallstown, Md.

18. Funeral director..... E. Miller Lamoreau

Address..... 4610 Liberty Hwy Ave

19. (For registrar)..... 1946..... Harry Miller  
(Signature)..... Deputy Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County.....

City or town..... Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No..... unknown  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... April 8  
19. 46 at 9:30 p.m.21. I CERTIFY that death occurred on the date above stated: that I attended deceased from November 6  
19. 03 to April 8  
19. 46and that I last saw h. .... E.R. alive on April 8  
19. 46Immediate cause of death..... Chronic Myocarditis  
DURATION Indef.Due to..... Generalized Arteriosclerosis  
DURATION Indef.

Due to.....

Other conditions.....  
(Include pregnancy within 8 months of death)Major findings of operations.....  
Date of op.Autopsy results..... none  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury..... Injured at work?

Signature..... Isadore Tuerk  
Address..... Catonsville 28, Md. M. D. or other

Date signed..... 4/9/46

SEARCHED

APR 15 1946

BUREAU V.R.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 232

03553

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

County.....

Baltimore

City or town.....

Franklintown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

10 years

Hospital, Institution, or street address where death occurred:.....

How long in hospital or institution?.....

J.

## 3. (a) FULL NAME

Elizabeth Wilhelmine Sakers

## 3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

F.

W.

Widowed

6. (b) Name of husband or wife

John W. Sakers

7. Birth date of deceased (mo., day, yr.)

Nov. 26 1862

6. (c) If alive, give age.....years

8. AGE:

Years

Months

Days

It less than one day

83

4

20

hrs.

min.

9. Birthplace.....

Queen Anne Co. Md.

(Town, county, and state)

10. Usual occupation.....

Housewife

11. Industry or business

William T. Sears

FATHER

MOTHER

12. Name.....

Md.

13. Birthplace.....

Md.

14. Maiden name.....

Elizabeth Crier

15. Birthplace.....

Md.

16. Informant.....

Lloyd E. Sakers

Address.....

Ingleside Ave.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof.....

4-18-46

(month) (day) (year)

Cemetery or crematory.....

Lorraine Park

Location.....

Woodlawn Md.

18. Funeral director.....

G. Howard Strong

Address.....

3207 W. North Ave.

19.

4/18

19

X6

A. W. Hedrick

Registrar

(Date typed by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

Md. Baltimore

City or town.....

Franklintown

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

Ingleside Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## MEDICAL CERTIFICATION

20. DATE OF DEATH

April 15<sup>th</sup> 1946 at 9:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 14, 1946, to April 15, 1946,

and that I last saw her alive on April 15, 1946.

Immediate cause of death

Cerebral hemorrhage 2 days

Due to Chronic hypertension

&amp; cerebral changes

DURATION

over  
than  
10 yrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

No autopsy

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause in which death could be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

Hemorrhage

Cotarsville Md. Date signed 4/16/46

M. D. or other

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-2

03554

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

## 1. PLACE OF DEATH

County BaltimoreCity or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 months - 29 daysHospital, Institution, or street address where death occurred: Hospital HomeHow long in hospital or institution? 11 months - 29 days

## 3. (a) FULL NAME

Mary Angela Sappington3. (b) Social Security Number none4. Sex F5. Color or race W (a) Single, married, widowed, or divorcedSingle

6. (c) Name of husband or wife.....

6. (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 4-7-18638. AGE: Years 83 Months 0 Days 22 If less than one day  
hrs. ..... min. ....9. Birthplace Libertytown - Md.  
(Town, county, and state)10. Usual occupation Housekeeper

11. Industry or business

12. Name Mrs. Augustine A. Sappington13. Birthplace Libertytown - Md.14. Maiden name Irene M. Mantz15. Birthplace Frederick Md.16. Informant James SappingtonAddress Libertytown - Md.17. Burial Burial Date thereof 5-2-46  
(Burial, cremation, or removal, which?) (month) (day) (year)Cemetery or crematory St. Peters CemeteryLocation Libertytown - Md.18. Funeral director C. E. Cline & SonAddress Frederick Md.19. 4-30-46 Harry J. Miller  
(Date rec'd by registrar) Deputy Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County FrederickCity or town Libertytown

(If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 29 1946

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Apr 29 1946 to Apr 29 1946and that I last saw h. alive on Apr 29 1946

Immediate cause of death

Perecrosis & heart attack DURATION 10 daysDue to Perecrosis & heart attackDiabetes

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

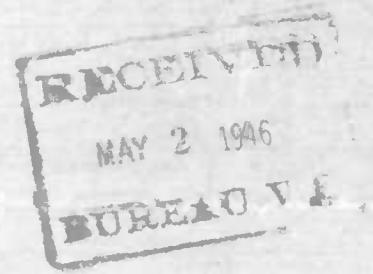
Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of Injury ..... Injured at work?

23. SIGNATURE Moses Stover M. D. or otherAddress Baltimore Date signed 4-30



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 23d

## CERTIFICATE OF DEATH

03555

Reg. Dist. No. 44

PLEASE WRITE PLAINLY, WITH UNTADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

1. PLACE OF DEATH:  
County..... Baltimore

City or town..... Fort Howard  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 Day

Hospital, institution, or street address where death occurred:

Vets. Adm. Hosp. Ft. Howard, Maryland

How long in hospital or institution? 1 Day

3.(a) FULL NAME

CHARLES E. SAYLOR

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Mrs. Miriam Saylor

7. Birth date of deceased (mo., day, yr.) 9-3-90

8. AGE:	Years 55	Months 7	Days 20	If less than one day ..... hrs. .... min.
---------	-------------	-------------	------------	--

9. Birthplace..... Pennsylvania  
(Town, County, and state)

10. Usual occupation..... School Bus Driver

11. Industry or business

12. Name	Abram Saylor
MOTHER FATHER	Franklin Co., Pa.

13. Birthplace	Alice L. Bowers
----------------	-----------------

14. Maiden name	Washington Co., Md.
-----------------	---------------------

15. Birthplace	Clinical Records, Vets. Adm. Hosp.
----------------	------------------------------------

16. Informant	Ft. Howard, Maryland
Address	

17. Burial	Date thereof April 30, 1946
(Burial, cremation, or removal. Which?)	(month) (day) (year)

Cemetery or crematory	Mt. Tabor Cemetery
Location	Fairview, Maryland

18. Funeral director	Snyder & Rowland
Address	Clear Spring, Md.

19. (April 30, 1946 registrar)	Archibald Purush Registrar
-----------------------------------	----------------------------------

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State..... Maryland County.....

City or town..... Clear Spring  
(If outside city or town limits, write RURAL and give nearest town)

Street No. .....  
(If rural, give LOCATION)

2.(a) If veteran, name war..... WW-I

3.(b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 23, 1946 at 3:46 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April 22, 1946, to April 23, 1946, and that I last saw him alive on April 23, 1946.

Immediate cause of death..... Pericarditis adhesive constrictiva

DURATION

Unknown

Due to.....

Due to.....

Other conditions Arteriosclerotic heart disease and Pulmonary emphysema  
(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results Substantiated above  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE Robert M. Cullison

R. M. CULLISON, M.D. ACT. CLIN. DIR.  
Ft. Howard, Md. Date signed 4-24-46



## BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH *(48)*Registered No. *41*

## 1. PLACE OF DEATH:

(a) Baltimore City, Maryland

Turners Station

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

## 3 (a) FULL NAME

3 (b) If veteran, name war

4. Sex

5. Color or race

Female Colored

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

Clarence

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Sept. 7, 1897

8. AGE: Years Months Days

48

If less than one day

hr. min.

9. Birthplace

Baltimore, Md.

(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

12. Name

William Dungee

13. Birthplace

Baltimore, Md.

14. Maiden Name

Ella Cain

15. Birthplace

Baltimore, Md.

Sarah K. Scott

16. (a) Informant

118 Sollers St. Rd.

(b) Address

Burial

(b) Date thereof

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Arthur Jem. Park

Location

Baltimore Co. Md.

18. (a) Funeral director

Mrs. George W. Holland

(b) Address

1636 Dundalk Ave.

APR 5 1946

19. (a) Death registration number

A. G. Hedgpeth

D. M. D.

Date registered

Apr 5 1946

A. G. Hedgpeth

D. M. D.

Address

Turners Sta. Md.

Date signed

4/3/46

M. D.

Signature

J. Thomas M.D.

Address

Turners Sta. Md.

Date signed

4/3/46

M. D.

Signature

J. Thomas M.D.

Address

Turners Sta. Md.

Date signed

4/3/46

M. D.

Signature

J. Thomas M.D.

Address

Turners Sta. Md.

Date signed

4/3/46

M. D.

Signature

J. Thomas M.D.

Address

Turners Sta. Md.

Date signed

4/3/46

M. D.

Signature

J. Thomas M.D.

Address

Turners Sta. Md.

Date signed

4/3/46

M. D.

Signature

J. Thomas M.D.

Address

Turners Sta. Md.

Date signed

4/3/46

M. D.

Signature

J. Thomas M.D.

Address

Turners Sta. Md.

Date signed

4/3/46

M. D.

Signature

J. Thomas M.D.

Address

Turners Sta. Md.

Date signed

4/3/46

M. D.

Signature

J. Thomas M.D.

Address

Turners Sta. Md.

Date signed

4/3/46

M. D.

Signature

J. Thomas M.D.

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Turners Sta. Md.

Date signed

4/3/46

M. D.

Signature

J. Thomas M.D.

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Turners Sta. Md.

Date signed

4/3/46

M. D.

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Turners Sta. Md.

Date signed

4/3/46

M. D.

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Date signed

4/3/46

M. D.

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Date signed

4/3/46

M. D.

Signature

J. Thomas M.D.

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Turners Sta. Md.

Date signed

4/3/46

M. D.

Signature

J. Thomas M.D.

Address

Turners Sta. Md.

Date signed

4/3/46

M. D.

Signature

J. Thomas M.D.

Address

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Date signed

4/3/46

M. D.

Signature

J. Thomas M.D.

Address

Turners Sta. Md.

Date signed

4/3/46

M. D.

Signature

J. Thomas M.D.

Address

Turners Sta. Md.

Date signed

4/3/46

M. D.

Signature

J. Thomas M.D.

Address

Turners Sta. Md.

Date signed

4/3/46

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Date signed

4/3/46

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Turners Sta. Md.

Date signed

4/3/46

M. D.

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Address

Turners Sta. Md.

Date signed

4/3/46

M. D.

Signature

J. Thomas M.D.

Address

Turners Sta. Md.

Date signed

4/3/46

M. D.

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J. Thomas M.D.

Address

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4/3/46

M. D.

Signature

J. Thomas M.D.

Address

Turners Sta. Md.

Date signed

4/3/46

M. D.

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Turners Sta. Md.

Date signed

4/3/46

M. D.

Signature

J. Thomas M.D.

Address

Turners Sta. Md.

Date signed

4/3/46

M. D.

Signature

J. Thomas M.D.

Address

Turners Sta. Md.

Date signed

4/3/46

M. D.

Signature

J. Thomas M.D.

Address

Turners Sta. Md.

Date signed

4/3/46

M. D.

Signature

J. Thomas M.D.

Address

Turners Sta. Md.

Date signed

4/3/46

M. D.

Signature

J. Thomas M.D.

Address

Turners Sta. Md.

Date signed

4/3/46

M. D.

Signature

J. Thomas M.D.

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Turners Sta. Md.

Date signed

4/3/46

M. D.

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Date signed

4/3/46

M. D.

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J. Thomas M.D.

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Turners Sta. Md.

Date signed

4/3/46

M. D.

Signature

J. Thomas M.D.

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Turners Sta. Md.

Date signed

4/3/46

M. D.

Signature

J. Thomas M.D.

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Turners Sta. Md.

Date signed

4/3/46

M. D.

Signature

J. Thomas M.D.

Address

Turners Sta. Md.

Date signed

4/3/46

M. D.

Signature

J. Thomas M.D.

Address

Turners Sta. Md.

Date signed

4/3/46

M. D.

Signature

J. Thomas M.D.

Address

Turners Sta. Md.

Date signed

4/3/46

M. D.

Signature

J. Thomas M.D.

Address

Turners Sta. Md.

Date signed

4/3/46

M. D.

Signature

J. Thomas M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1316

03557

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:  
Balto.  
County.....  
City or town.....  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?.....  
Hospital, Institution, or street address where death occurred:.....  
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
Balto.  
County.....  
State.....  
City or town.....  
(If outside city or town limits, write RURAL and give nearest town)  
Street No.....  
Patapsco Rd.  
(If rural, give LOCATION)

## 3. (a) FULL NAME

MARGARET A. SHAKESPEARE

## 3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	Widow
B.(b) Name of husband or wife..... Harry G. Shakespeare		
7. Birth date of deceased (mo., day, yr.)..... 9-26-73		
8. AGE: Years      Months      Days      If less than one day		
72	6	23
		hrs.      min.

9. Birthplace..... Oxford, Md.  
(Town, county, and state)

10. Usual occupation..... House

11. Industry or business  

FATHER	12. Name..... John S. Haddaway
	Oxford, Md.
MOTHER	13. Birthplace..... Mary Fox

14. Maiden name..... Oxford, Md.

15. Birthplace..... Oxford, Md.

16. Informant..... Mr. Raymond H. Shakespeare

Address..... Patapsco Rd., Box 298, Essex 21

17. Burial..... Date thereof..... 4/23/46  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Loudon Park Cem.

Location..... Balto., Md.

18. Funeral director..... WM. J. TICKNER & SONS

Address..... Balto., Md.

4/23 46  
Date rec'd by registrar..... 19..... Registrar..... P

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... April 19, 1946, at 3:10 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 19, 1946, to April 19, 1946,  
and that I last saw her alive on April 19, 1946.

Immediate cause of death..... Chronic nephritis

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury.....

Injured at work?

23. SIGNATURE..... James F. White, M.D.

M. D. or other

Address..... 7601 Eastern Ave., Baltimore 24, Md. Date signed..... 4/20/46

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03558

## CERTIFICATE OF DEATH

Reg. Dist. No. 3d

## 1. PLACE OF DEATH:

County.....

Baltimore

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? .....

1 month

Hospital, institution, or street address where death occurred:

City home for Invalids

How long in hospital or institution? .....

1 month

## 3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Widowed

6. (b) Name of husband or wife.....

Mary Elizabeth Hawker

6. (c) If alive, give age .....

years

7. Birth date of deceased (mo., day, yr.)

September 25, 1857

8. AGE:

Years

Months

Days

If less than one day

88

6

9

hrs. .... min.

9. Birthplace.....

Howard County, Md.

(Town, county, and state)

10. Usual occupation.....

Carpenter

Retired

11. Industry or business

MOTHER

FATHER

12. Name.....

Unknown

13. Birthplace

Unknown

14. Maiden name.....

Unknown

15. Birthplace

16. Informant.....

George Calvin Hawker

Address

1253 Stevens Avenue, Baltimore

17. Burial

Burial

Date thereof ..... (month) (day) (year)

(Burial, cremation, or removal, Whicht)

Cemetery or crematory.....

London Park

Location

Baltimore, Maryland

18. Funeral director.....

George L. Schwab

Address

2101 Frederick Avenue

19. 4-#

1946

(Date rec'd by registrar)

Harry V. Miller

Deputy Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County.....

City or town..... Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1431 Washington Blvd.

(If rural, give LOCATION)

2.(a) If veteran, name war..... None

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

20. DATE OF DEATH

April 3,

1946, at 1:45 P.M.

I CERTIFY that death occurred on the date above stated; that I attended deceased from

L 1/2

1946

to 4-3 1946

and that I last saw h... unalive on

4-3

1946

Immediate cause of death.....

Myocardial Failure

DURATION

3 hr

Due to.....

Myocardial Arrest from

myocardial disease

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury.....

Injured at work?

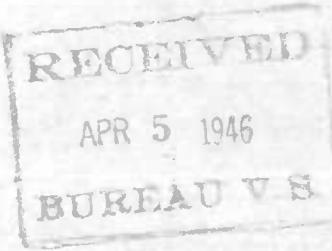
23. SIGNATURE

Joseph G. Laukaitis, M.D.

M. D. or other

Address..... 609 Washington Blvd.

Date signed 4/3/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of birth date & age of deceased and MARYLAND STATE DEPARTMENT OF HEALTH  
date of death is shown on FILE No. 104 MAY 13 1946 CERTIFICATE OF DEATH

2411 N. Charles St., Baltimore 1946

Reg. Dist. No. 50

03559

## 1. PLACE OF DEATH

County

Baltimore

City or town

Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 years - 10 mos

Hospital, Institution, or street address where death occurred:

HAARLEM LODGE

How long in hospital or institution? 2 years - 10 mos.

## 3. (a) FULL NAME

SAMUEL S.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Maryland County

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 18 W. Read

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

SMALL

4. Sex

Male White Married

B.(b) Name of husband or wife

MARY E. SMALL

7. Birth date of deceased (mo., day, yr.)

SEPT. 9 - 1864 - 1863

8. AGE:

Years Months Days If less than one day  
82 84 7 14 hrs. min.

9. Birthplace

Pennsylvania

(Town, county, and state)

10. Usual occupation

Mechanical Engineer

11. Industry or business

Rail Road Business

MOTHER FATHER

12. Name George Small

13. Birthplace Pennsylvania

14. Maiden name

YORK RD.

15. Birthplace

Dr. MARY E. SMALL

16. Informant

Address 18 W. Read Street

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Apr. 26 - 46

(month) (day) (year)

Cemetery or crematory Locustine Park

Location Meadowlawn Md.

18. Funeral director J. B. Whipple &amp; Son

Address 1300 Easton Place

4/26 1946 Death rec'd

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

April 26, 1946 at 12:08 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

August 1, 1944 to April 23, 1946

and that I last saw him alive on April 23, 1946

Immediate cause of death

Cardiac Decompensation  
and failure

Due to

Generalized Arteriosclerosis years

Due to

Senile Degenerative Changes years

Other conditions

Senile Psychosis 3 years

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

Arthur J. Michalland M.D.

Address Highland Lodge Atansville, Md. Date signed May 7, 1946

Cert of Birth Balt City

#99098

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 950

## CERTIFICATE OF DEATH

03560 42  
Reg. Dist. No.

Maj. 4/10 - 4/11/46

1. PLACE OF DEATH:  
County.....  
City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

5729 First av

How long in hospital or institution?

3. (a) FULL NAME

Paul Edwin Somers

4. Sex      5. Color or race      6. (a) Single, married, widowed, or divorced

m w married

6. (b) Name of husband or wife.....

Mary Alice Somers

7. Birth date of deceased (mo., day, yr.) Dec. 6 1886 1887

8. (c) If alive, give age 53 years

8. AGE: Years      Months      Days      It less than one day

58 5 3 29 hrs. min.

9. Birthplace.....

(Town, county, and state)

Balt Md

10. Usual occupation.....

Waiter

11. Industry or business.....

retired

12. Name.....

Unknown

13. Birthplace.....

Unknown

14. Maiden name.....

Unknown

15. Birthplace.....

Unknown

16. Informant.....

Mary Alice Somers

Address 5729. First av

17. (Burial, cremation, or removal. Which?) Date thereof April 6 46

(month) (day) (year)

Cemetery or crematory.....

London Park

Location.....

Balt Md

18. Funeral director.....

George L Schaal

Address 2101 Frederick av

19. Date rec'd by registrar.....

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md. County..... Balt.

City or town..... Balt.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 5729 First av

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

215-10-2796

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... April 4 1946 at 3:20 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to..... 19.....

and that I last saw h..... alive on..... 19.....

Immediate cause of death.....

Coronary occlusive

Due to.....

Cardio vascular disease

Duration.....

Other conditions..... sudden death

Injury..... injury

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

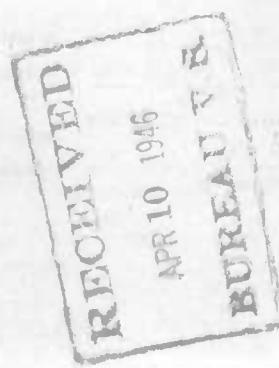
Injured at home, farm, industry, public place (where?) .....

Means of injury..... Injured at work? .....

23. SIGNATURE..... George Kieffer Esq. &amp; Belle

M. D. or other.....

Address..... 1010 Leedan Date signed..... 4-4-46



## CERTIFICATE OF DEATH

PRO  
Registered No. 30

## 1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 5501 Edmondson Ave

(c) Hospital or institution: Blood Nursing Home

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

## 3. (a) FULL NAME

3. (b) If veteran, name war

No

3. (c) Social Security Account

No. none

4. Sex

5. Color or race

Male white

6. (a) Single, married, widowed, or

divorced.

7. Name of husband or wife

Linda Stafford

6. (c) If alive, give age

years

8. Birth date of deceased (mo., day, yr.) 1/31/1861

8. AGE: Years Months Days

If less than one day

85 2 31

hr. min.

9. Birthplace Preston, Md.

(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

12. Name John D. Stafford

13. Birthplace Bel Coates

14. Maiden Name Bel

15. Birthplace Bel

16. (a) Informant Mr. James J. Stafford

(b) Address 720 Lummus St

17. (a) Burial (b) Date thereof 4/25/46

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Washington

Location Laurel, Md.

18. (a) Funeral director C. M. Richardson

(b) Address 10th &amp; E. Baltimore

19. (a) 4/23/46 (b) 4/25/46

(Date rec'd by registrar)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 720 Lummus St

(If rural give location)

(e) Citizen of foreign country?

If yes, name country

(Yes or No)

## MEDICAL CERTIFICATION

20. DATE OF DEATH 4-22 1946 at 6:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1946 to day 19, and that I last saw him alive on April 21, 1946.

Immediate cause of death

acute myocardial infarction

Duration

Due to arterioclerosis

and severe anemia

Due to Cancer of gastrointestinal tract;

primary site not determined

Other Conditions post-malignancy

in gastro-intest- tract

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public

place?

(Specify type of place)

While at work?

(e) Means of injury

23. Signature Schreyer

M. D.

Address 3921 Edmondson

Date signed 4-22

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

03562

Reg. Dist. No. 3

## 1. PLACE OF DEATH:

County.....

City or town.....

Names P. O. Owens Mall

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

## 3. (a) FULL NAME

Mary Estelle Staples

## 3. (b) Social Security Number

4. Sex

Female

5. Color or race

Col

6. (a) Single, married, widowed, or divorced

Married  
Edward Staples

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age ..... years  
1914

8. AGE: Years

32

Months

Days

If less than one day

hrs. min.

9. Birthplace

Westmoreland Co., Va

(Town, county, and state)

10. Usual occupation.....

Domestic

11. Industry or business

12. Name.....

Robert Parker

13. Birthplace

Va

14. Maiden name.....

Robertanna Wilson

15. Birthplace

Va

16. Informant.....

Joseph W. Wilson

Address

23 Grove St. Rutherford, NJ

17. Burial

(Burial, cremation, or removal, which?)

Date thereof.....  
(month) (day) (year)  
4/13/46

Cemetery or crematory.....

Brown Cemetery

Location.....

Westmoreland Co., Va.

18. Funeral director.....

Elroy O. Wilson

Address

1000 Blantley Ave

19. Date rec'd by registrar

Apr 10

1946

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md

County.....

City or town.....

Owings Mill

Street No.....

Caes Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## MEDICAL CERTIFICATION

20. DATE OF DEATH

4/10/46

1946 at 1045 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

mr.

1945 to Apr 10 1946

and that I last saw her alive on

Apr 10

1946

Immediate cause of death.....

acute pulmonary edema

DURATION

8 hrs

Due to.....

Hypertension cardiac

a year

.....

vascular disease

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE

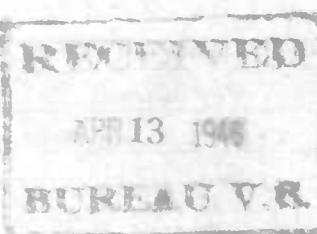
Patricia P. Williams

M. D. or other

Address.....

Owings Mill

Ind. Date signed 4/10/46



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 23

03563

## CERTIFICATE OF DEATH

Reg. Dist. No. 4X

## 1. PLACE OF DEATH:

Baltimore

County.....

Fort Howard

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 Days.

Hospital, institution, or street address where death occurred:

Vets. Adm. Hosp., Ft. Howard, Maryland

How long in hospital or institution? 11 Days.

## 3. (a) FULL NAME

JAMES H. THOMPSON

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Male Colored Divorced

6.(b) Name of husband or wife Fannie

7. Birth date of deceased (mo., day, yr.) July 7, 1901 6.(c) If alive, give age years

8. AGE: Years Months Days If less than one day  
44 7 29 hrs. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Laundry Worker

## 11. Industry or business

MOTHER FATHER 12. Name Unknown

13. Birthplace Unknown

14. Maiden name Fannie ?

15. Birthplace Unknown

16. Informant Clinical Records, Vets. Adm. Hosp.

Ft. Howard, Md.

Address Burial April 9, 1946

17. (Burial, cremation, or removal. Which?) Cemetery or crematory Baltimore National Cem.

Location Baltimore Co. Md.

18. Funeral director Mrs. George W. Holland

Address 1631 Druid Hill Ave.

19. 49 48 Date rec'd by registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County .....

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1933 Druid Hill Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war .....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 5, 1946, at 3:35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 25, 1946, to April 5, 1946, and that I last saw him alive on April 5, 1946.

Immediate cause of death

Thrombosis, cerebral

DURATION

3 wks

Due to

Due to

Other conditions Hemiplegia, right

3 wks

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert M. Cullison

R.M. CULLISON, M.D. ACT. MCP, ENDIR.

Ft. Howard, Md. Date signed 4-5-46

Registrar

Otter Gannet  
S. G.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 808

## CERTIFICATE OF DEATH

03564

80

Reg. Dist. No.

## 1. PLACE OF DEATH:

County..... **Baltimore**  
 City or town..... **Catonsville**  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? **12 days**

Hospital, institution, or street address where death occurred:

**Spring Grove State Hospital**How long in hospital or institution? **12 days**

## 3. (a) FULL NAME

**Joseph E. Thompson, Jr.**

## 4. Sex

## 5. Color or race

## 6.(a) Single, married, widowed, or divorced

**male****white****single**

## 6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

## 7. Birth date of deceased (mo., day, yr.)

**November 14, 1926**

## 8. AGE: Years      Months      Days      If less than one day

**19      5      4      hrs.      min.**

## 9. Birthplace

**Washington, D. C.**

(Town, county, and state)

## 10. Usual occupation

**none**

## 11. Industry or business

**none**

## 12. Name

**Joseph Thompson**

## 13. Birthplace

**Maryland**

## 14. Maiden name

**Hilda L. Thompson**

## 15. Birthplace

**Maryland**

## 16. Informant

**Hospital records**

## Address

**Catonsville-28, Md.**

## 17. Burial

(Burial, cremation, or removal, Which?) Date thereof **4/20/46**  
(month) (day) (year)

## Cemetery or crematory

**Fort Lincoln Cemetery**

## Location

**Prince George County**

## 18. Funeral director

**L. W. Chambers Co.**

## Address

**Rivendale Maryland**19. (For use by registrar) **4-19 1946****Harry J. Miller****Registrar**

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... **Maryland** County..... **Anne Arundel**City or town..... **Gambrills Post Office**  
(If outside city or town limits, write RURAL and give nearest town)

Street No. -

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH **April 18** 19. **46**, at **12:40 p.m.**21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **April 6** 19. **46**, to **April 18** 19. **46**and that I last saw h. im...alive on **April 18** 19. **46**

Immediate cause of death

**Encephalitis**

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results **as above**

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

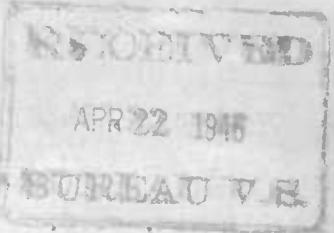
Means of injury

Injured at work?

23. SIGNATURE **Isadore Tuerk, M.D.**

M. D. or other

Address **Catonsville-28, Md.** Date signed **4-18-46**



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 480

03565

## CERTIFICATE OF DEATH

Reg. Dist. No. 4-46

## 1. PLACE OF DEATH:

County.....

City or town.....

Baltimore  
Burner's Sta - md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

## 3. (a) FULL NAME

Alice T. Tyler

4. Sex

5. Color or race

6. Civil status: married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years      Months      Days      If less than one day

9. Birthplace.....  
(Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER

12. Name.....

13. Birthplace.....

14. Maiden name.....

15. Birthplace.....  
Estella16. Informant.....  
Address

17. (Burial, cremation, or removal. Which?) Cemetery or crematory..... Date thereof.....

(month) (day) (year)

Location.....

18. Funeral director.....

Address

19. (Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

City or town.....

Street No. ....

County.....

(If outside city or town limits, write RURAL and give nearest town)

119 Seller's Point Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

April 13<sup>th</sup>

1946 at 2:10 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from January 1946 to April 1946, and that I last saw her alive on April 12<sup>th</sup> 1946.

Immediate cause of death.....

Carcinoma of uterus

DURATION

Due to.....

Unknown

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE

J. H. Thomas M.D.

M. D. or other

Address.....

Date signed

Registrar

P

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MV

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 17020

03566 P

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County..... **Baltimore**  
City or town..... **Catonsville**

(If outside city or town limits, write RURAL and give nearest town)

**2 months, 27 days**How long in above place of death? **2 months, 27 days**

Hospital, institution, or street address where death occurred:

**Spring Grove State Hospital**  
**2 months, 27 days**

How long in hospital or institution?

## 3. (a) FULL NAME

**Leonard Uhler (Leonard Spurrier Uhler)**4. Sex **male** 5. Color or race **white** 6.(a) Single, married, widowed, or divorced  
**married**6.(b) Name of husband or wife..... **Margaret V. Sharp**6.(c) If alive, give age **56** years7. Birth date of deceased (mo., day, yr.) **May 11, 1884**8. AGE: Years **61** Months **10** Days **25** If less than one day  
hrs. ..... min. ....9. Birthplace..... **Pikesville, Maryland**  
(Town, county, and state)10. Usual occupation..... **Railroad conductor**11. Industry or business..... **Railroad**12. Name..... **Nicholos Uhler**13. Birthplace..... **Carroll County, Maryland**14. Maiden name..... **Anne Spurrier**15. Birthplace..... **Unionbridge, Maryland**16. Informant..... **Hospital records**Address..... **Catonsville-28, Maryland**17. Burial..... **Eurial** Date thereof..... **4/9/46**  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory..... **DRUID RIDGE CEMETERY**Location..... **BALTIMORE, MARYLAND**18. Funeral director..... **HENRY SANDER & SONS, INC.**Address..... **NORTH AVE. & BROADWAY**19. **4-8 4-6** **Death** **Registrar**  
(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... **Maryland** County.....City or town..... **Baltimore-13**  
(If outside city or town limits, write RURAL and give nearest town)Street No..... **3114. Lawnview Avenue**

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

**705-09-3797**

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... **April 5** 19... **46** at **7:00 AM**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to..... 19.....

and that I last saw h..... alive on..... 19.....

Immediate cause of death.....

DURATION

*Crushed left Chest  
rib fractured.  
punctured lung on left side  
due to  
Chest contains fluid  
General injury to left chest*

(Include pregnancy within 6 months of death)

Major findings or operations.....

Date of op.

Autopsy results..... *as above*

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... **Accident** Date of..... **April 2, 46**Where did injury occur?..... **Catonsville Ball Field** (City or town) (County) (State)Injured at home, farm, industry, public place (where?) *Spring Grove State Hospital*Means of Injury..... *run over auto truck* Injured at work? *no*23. SIGNATURE..... *Geo Wm Kieffer* M. D. or other *Surgeon*Address..... **1010 Heede an** Date signed **Apr 5, 46**

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 332

## CERTIFICATE OF DEATH

03567

Reg. Dist. No. 31

## 1. PLACE OF DEATH:

County

Baltimore Catonsville

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 13 months

Hospital, institution, or street address where death occurred:

Apitz Home for Dwarfs

How long in hospital or institution?

13 months

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

2608 Lehman Street

(If rural, give LOCATION)

2.(a) If veteran, name war

None

## 3. (a) FULL NAME

Mary Ellen Wade

## 3. (b) Social Security Number

None

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Female

White

Single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6.(c) If alive, give age

years

March 16, 1860

Years

Months

Days

If less than one day

86

-

18

hrs.

min.

9. Birthplace

Arbutus, Baltimore County, Md.

(Town, County, and state)

10. Usual occupation

Housework

11. Industry or business

George H. Wade

MOTHER FATHER

12. Name

Maryland

13. Birthplace

Maryland

14. Maiden name

Maria Isela

15. Birthplace

Maryland

16. Informant

James H. Wade

Address

2608 Lehman Street

17. Burial

Burial Date thereof 4-6-46

(Burial, cremation, or removal, which?)

(month) (day) (year)

Cemetery or crematory

London Park

Location

Baltimore, Maryland

18. Funeral director

George L. Schubert

Address

2101 Frederick Avenue

19. 4-6-1946

Harry Miller

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

April 3, 1946, at 11:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 3 1946 to Apr 3 1946

and that I last saw her alive on Apr 3 1946

Immediate cause of death

Cerebral Hemorrhage

DURATION

3 days

Due to

Cerebral Arteriosclerosis

Due to

Sclerosis

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

George H. Wade M. D. or other

Address: Second floor Date signed 2/4



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 15

## CERTIFICATE OF DEATH

Reg. Dist. No. 03568 32

## 1. PLACE OF DEATH:

County.....  
Balto.  
City or town.....  
Pikesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Campfield Rd.

How long in hospital or institution?

## 3. (a) FULL NAME

CHARLES WALTHER

3. (b) Social Security Number  
none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife.....

Anna M. Walther

7. Birth date of deceased (mo., day, yr.)  
March 25, 1858

6.(c) If alive, give age..... years

8. AGE:	Years	Months	Days	It less than one day
	88	0	13	hrs. min.

9. Birthplace.....  
(Town, county, and state)

10. Usual occupation..... Retired Machinist

11. Industry or business..... Sun Papers

12. Name..... Unknown

13. Birthplace.....

14. Maiden name..... Unknown

15. Birthplace.....

16. Informant..... Mr. Edwin H. Schneider

Address..... 4103 Forest Park Ave.

17. Burial..... Date thereof..... 4/11/46  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Loudon Park Cem.

Location..... Balto., Md.

18. Funeral director..... WM. J. TICKNER &amp; SONS

Address..... Balto., Md.

19. 4-9-46  
(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md. County..... Balto.

City or town..... Pikesville  
(If outside city or town limits, write RURAL and give nearest town)

Street No..... Campfield Rd.

(If rural, give LOCATION)  
none

2.(a) If veteran, name war.....

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... April 8, 1946, at 1:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 7<sup>th</sup>, 1946, to April 8, 1946, and that I last saw him alive on April 7<sup>th</sup>, 1946.

Immediate cause of death..... Chronic Myoecarditis

Due to..... arterio-sclerosis

Due to.....

Other conditions..... Senility, terminal pneumonia

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... E. J. Nichols, M.D.

M. D. or other

Address..... Pikesville - 8, Md. Date signed 4/9/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

03569

Reg. Dist. No. 300

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH:

County.....  
City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 yrs. 4 mos. 27 days.

Hospital, institution, or street address where death occurred:

Spring Grove State Hospital  
5 yrs. 4 mos. 27 days

How long in hospital or institution?

## 3.(a) FULL NAME

Marian Warden

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Singh

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) October 22, 1872 years

8. AGE: Years Months Days If less than one day

73 6 6 hrs. min.

9. Birthplace.....  
(Town, county, and state)

10. Usual occupation.....

11. Industry or business

12. Name..... John T. Warden

13. Birthplace..... Unknown

14. Maiden name..... Emma A. Henderson

15. Birthplace..... Unknown

16. Informant..... Hospital Records

Address..... Spring Grove State Hospital

17. Burial..... Date thereof.....

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Good Hope Cem.

Location..... Newberg Chapel Cem. Md.

18. Funeral director..... Dr. Chamberlain Co.

Address..... 517-11th St. S.E.

19. 4-28-46 Date rec'd by registrar..... Harry L. Wood, Jr. Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Washington, D.C. County.....

City or town..... Anacostia Station  
(If outside city or town limits, write RURAL and give nearest town)

Street No. -

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... April 28 1946 at 1:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec. 1 1940 to April 28 1946

and that I last saw her alive on April 28 1946

Immediate cause of death.....

Chronic Myocarditis

Due to.....

Hypertension Cardiac  
Muscular Disease

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

None

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

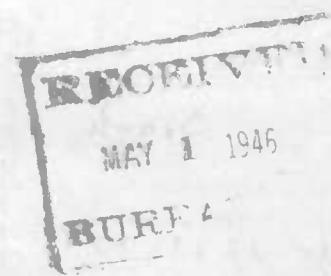
Injured at work?

23. SIGNATURE.....

Donald Jank, M.D.

M. D. or other

Address..... Spring Grove State Hosp. Date signed 4-28-46



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-10)

03570

30

## CERTIFICATE OF DEATH

Reg. Diat. No. ...3.C

1. PLACE OF DEATH: County..... City or town..... (If outside city or town limits, write RURAL and give nearest town)			2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State..... County..... City or town..... (If outside city or town limits, write RURAL and give nearest town)		
How long in above place of death? Hospital, Institution, or street address where death occurred: 115 Newburg Ave.			Street No..... (If rural, give LOCATION) 115 Newburg Ave.		
How long in hospital or institution?			2.(a) If veteran, name war		
3.(a) FULL NAME <b>GEORGIANNA WATSON</b>			3.(b) Social Security Number --		
4. Sex Female		5. Color or race White		6.(a) Single, married, widowed, or divorced Married	
Frank W. Watson					
6.(b) Name of husband or wife					
6.(c) If alive, give age.....years 7. Birth date of deceased (mo., day, yr.) Feb. 19, 1874					
8. AGE: Years 72 Months 2 Days 5 If less than one day .....hrs. .....min.					
9. Birthplace..... (Town, county, and state) Baltimore					
10. Usual occupation..... Housewife					
11. Industry or business					
MOTHER FATHER	12. Name..... Thomas G. DeFord				
	13. Birthplace..... Balto.				
MOTHER	14. Maiden name..... Georgianna Brady				
	15. Birthplace..... Balto.				
16. Informant..... Mr. Albert DeFord Address 4429 Clifton Rd. Balto.					
17. Burial..... (Burial, cremation, or removal. Which?) Date thereof..... Date thereof..... (month) (day) (year) 4/27/46 Cemetery or crematory..... Loudon Park Cem. Location..... Balto., Md.					
18. Funeral director..... WM. J. TICKNER & SONS Address Balto., Md.					
19. 4/26 1946 A. W. Hedrick M. D. or other (Date rec'd by registrar) (Signature) D. M. Registrar Address Catonsville-28, Md. Date signed 4/25/46					
MEDICAL CERTIFICATION April 24, 1946, at 12:25 P.M.					
20. DATE OF DEATH..... March 1, 1946, to April 24, 1946					
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from and that I last saw her alive on April 24, 1946.					
Immediate cause of death..... Central Hemorrhage					
Due to..... Chronic Cardio-Vascular-Renal Disease					
Due to.....					
Other conditions.....					
(Include pregnancy within 3 months of death)					
Major findings of operations.....					
Antopsy results.....					
PHYSICIAN: Please underline the cause in which death should be charged statistically.					
22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide..... Date of..... Where did injury occur?..... (City or town) (County) (State) Injured at home, farm, industry, public place (where?) Means of injury..... Injured at work?					
23. SIGNATURE..... William K. Gallagher, M.D. M. D. or other Address Catonsville-28, Md. Date signed 4/25/46					

**PLAINLY, WITH UNFADING INK.** Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

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V5 A15

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

832

03571

## CERTIFICATE OF DEATH

Reg. Dist. No.

40

## 1. PLACE OF DEATH:

County.....

Baltimore

City or town.....

Notch Cliff near Taneytown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

## 3. (a) FULL NAME

Sister Mary Clotilde Way

4. Sex..... 5. Color or race..... 6.(a) Single, married, widowed, or divorced

Female White Single

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo. day, yr.)..... Oct. 23, 1890

8. (c) If alive, give age..... years

8. AGE: Years Months Days If less than one day  
55 5 8 hrs. min.9. Birthplace..... Saginaw Mich.  
(Town, county, and state)

10. Usual occupation..... Teacher

## 11. Industry or business

12. Name..... Ignatius Way

13. Birthplace..... St. Agatha, Canada

14. Maiden name..... Frances Sittner

15. Birthplace..... St. Agatha, Canada

16. Informant..... St. Mary Clara

Address..... Notch Cliff, Md.

17. Burial..... Date thereof..... Apr. 4/46  
(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory..... Glenwood

Location..... 20101 Gandy Dr

18. Funeral director..... Rev. M. G. Smith Jr.

Address..... 811 N. 36th St. Philadelphia

19. Date recd by registrar..... Apr. 2/46

19. Date recd by registrar..... Apr. 2/46

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md.

County..... Baltimore

City or town..... Notch Cliff near Taneytown

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... April 1, 1946, at 6:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 22, 1941, to April 1, 1946

and that I last saw her alive on March 27, 1946

Immediate cause of death.....

Hypoplexy

DURATION

Sudden

Due to.....

Due to.....

Other conditions..... Arteriosclerosis and Hypertension

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

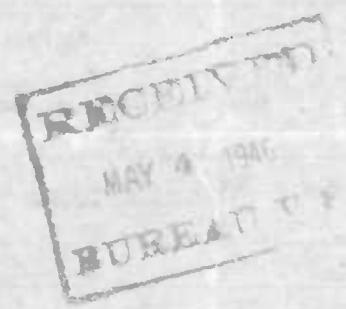
Injured at work?

23. SIGNATURE..... Ruth Green Jr.

M. D. or other

Address..... Towson

Date signed..... Apr. 2/46



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 33

## CERTIFICATE OF DEATH

03572

32

Reg. Dist. No.

## 1. PLACE OF DEATH:

County.....Baltimore  
City or town.....Roslyn

(If outside city or town limits, write RURAL and give nearest town)

1 Yr.

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

George W. Wilhelm

## 3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife.....Mary E. Wilhelm

6.(c) If alive, give age.....years

7. Birth date of deceased (mo. day, yr.)  
Feb. 17, 18728. AGE: Years  
74 Months  
2 Days  
4 If less than one day  
hrs.  
min.9. Birthplace.....New Freedom, Pa.  
(Town, county, and state)10. Usual occupation.....Machinist

## 11. Industry or business

12. Name.....Jacob Wilhelm  
Pa.13. Birthplace.....Pa.14. Maiden name.....Margaret Boone15. Birthplace.....Pa.16. Informant.....Mrs. Mary E. WilhelmAddress.....Old Court Rd., Roslyn

## 17. Burial

Date thereof.....Apr. 24, 1946  
(Burial, cremation, or removal. Which?)  
(month) (day) (year)Cemetery or crematory.....Mt. OliveLocation.....Roslyn, Md.18. Funeral director.....D. Howard StrongAddress.....3207 W. North Ave.19. 4-22-46  
(Date rec'd by registrar)E. E. Nichols  
Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....Md. County.....BaltimoreCity or town.....Roslyn  
(If outside city or town limits, write RURAL and give nearest town)Street No.....Old Court Rd. near Mill Road  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

## MEDICAL CERTIFICATION

3.20

2D. DATE OF DEATH.....April 21, 1946 at p.m.21. CERTIFY that death occurred on the date above stated; that I attended deceased from  
Jan 15, 46 to Apr 21, 46  
and that I last saw him alive on April 21, 46

Immediate cause of death.....

Sarcomea of left side  
of face & neck  
Due to

DURATION

1/12 yrs

Due to

General Asthma

Other conditions.....  
(Include pregnancy within 8 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)..... A

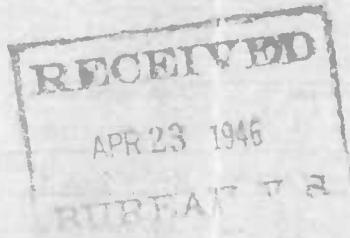
Means of injury.....

Injured at work?

23. SIGNATURE.....E. E. Nichols M.D.

M. D. or other

Address.....Pikesville - 8, Md. Date signed 4-22-46



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 189

## CERTIFICATE OF DEATH

03573

Reg. Dist. No.....

## 1. PLACE OF DEATH:

County.....Baltimore  
 City or town.....Bare Hills, Baltimore Co.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....NoneHospital, Institution, or street address where death occurred:  
Woods at Bare Hills

How long in hospital or institution?.....

## 3. (a) FULL NAME

Donald D Winegar4. Sex  
Male5. Color or race  
White6. (a) Single, married, widowed, or divorced  
Single

## 6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)  
Feb 25 - 1930

6. (c) If alive, give age.....years

8. AGE: Years  
16 Months  
1 Days  
18 If less than one day  
hrs. .... min.9. Birthplace.....Birmingham, Ala.  
(Town, county, and state)10. Usual occupation.....School11. Industry or business.....School12. Name of FATHER.....Lewis M. Winegar13. Birthplace.....Birmingham, Ala.14. Maiden name.....Ruby Lee Jones15. Birthplace.....Birmingham, Ala.16. Informant.....Lewis WinegarAddress.....62 Reed st.17. Burial.....Burial Date thereof.....April 17-46  
(Burial, cremation, or removal, Which?)  
(Month) (day) (year)Cemetery or crematory.....Birmingham CemeteryLocation.....Birmingham, Ala.18. Funeral director.....Charles J. LowellAddress.....2427 Edmondson Ave.19. Date rec'd by registrar.....4/15/46 19.....X6 A.C. Hedrick  
D.M. Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....Md. County.....City or town.....Bare Hills, Baltimore Co.  
(If outside city or town limits, write RURAL and give nearest town)Street No.....Woods at Bare Hills  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number  
none

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....April 1319.....46 at 1230 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....Home 19.....to 19.....  
and that I last saw h.....alive on 19.....to 19.....

## Immediate cause of death.....

Gunsight thru autumn chest, lung  
and heartDue to.....Accident

Due to.....

## Other conditions.....

(Include pregnancy within 3 months of death)

## Major findings or operations.....

Date of op.

## Autopsy results.....

PHYSICIAN: Please underline the cause in which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....Accident Date of.....April 13, 1946.Where did injury occur?.....Bare Hills, Baltimore Co. Md. (City or town) (County) (State)Injured at home, farm, industry, public place (where?)  
WoodsMeans of Injury.....Companion tripped firey 22 rifle Injured at work? No23. SIGNATURE.....Rollin C. Hudson M.D. D.M.E.

M. D. or other

Address.....Towson, Md. Date signed.....4/13/46

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

## CERTIFICATE OF DEATH

03574

Reg. Dist. No.

## 1. PLACE OF DEATH:

County... Baltimore  
 City or town River Van Road: Chase: Md.  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Orie E. Wise

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife Amelia M. Wise

7. Birth date of deceased (mo., day, yr.) December 15, 1886 6.(c) If alive, give age 62 years

8. AGE: Years 59 Months 4 Days 15 If less than one day  
hrs. ..... min. ....

9. Birthplace Talbot County: Md.  
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business

12. Name William Wise  
13. Birthplace Talbot County: Md.

14. Maiden name -

15. Birthplace -

16. Informant Mrs. Amora M. Wise

Address River Van Road: Chase: Md

17. Burial Date thereof 5/31/46  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Holy Rosary Cemetery

Location 4830 Belair Road

18. Funeral director Howard W. Blight Jr.

Address 4914 Belair Road

19. 5/1/46 (Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Baltimore

City or town Twin River Beach  
(If outside city or town limits, write RURAL and give nearest town)

Street No. River Van Road: Chase: Md.  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (b) Social Security Number \_\_\_\_\_

## MEDICAL CERTIFICATION

2D. DATE OF DEATH April 30 1946, at 2 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 2 1945, to April 30 1946

and that I last saw him alive on April 30, 1946

Immediate cause of death Left Hemiplegia

Subcortical Insufficiency

Due to Hypertension: Cordic-Vascular Disease

DURATION

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op.

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE John T. Kowalski

M. D. or other

Address 2529 Eastern Ave. Date signed 5/1/46

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 934

## CERTIFICATE OF DEATH

03575

Reg. Dist. No. 30

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:  
 County Balt. co. 16 Fusting Ave.  
 City or town Catonsville  
 (If outside city or town limits, write RURAL NEAR and give town)  
 Street address, hospital, or institution:

Stay in hospital or Inst. (yrs., or mos., or days)  
 Stay in this community (yrs., or mos., or days) Life

## 3. (a) FULL NAME

Charles W Wisner

4. Sex M	5. Color or race W	6.(a) Single, married, widowed, or divorced Widowed
----------	--------------------	---

B (b) Name of husband or wife Mary E

7. Birth date of deceased (mo., day, yr.) Jan. 5 1846

8. AGE: Years 100	Months 3	Days 12	If less than one day hrs.	min.
-------------------	----------	---------	---------------------------	------

9. Birthplace Maryland  
(town, county, and state)

10. Usual occupation Retired

11. Industry or business

12. Name Jacob Wisner

13. Birthplace Maryland

14. Maiden name Emily Powers

15. Birthplace Baltimore Co. Md.

16. Informant Dr. Jacob Wisner

Address 2125 Maryland Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/19/46  
(month) (day) (year)

Cemetery or crematory Druid ridge Cemt.

Location Pikesville Md.

18. Funeral director J. L. Yikle &amp; Sons

Address 1000 Eutaw Place Balt. Md.

4-15-46 19  
(Date rec'd by registrar) *Deafedale*  
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)

State Maryland County Balt.  
 City or town Catonsville Ward No.  
 (If outside city or town limits, write RURAL NEAR and give town)  
 Street No. 16 Fusting Ave.  
 (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (b) Social Security Number

## MEDICAL CERTIFICATION

2D. DATE OF DEATH Apr. 17 1946, at 12:45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
 Apr. 7 1946, to Apr. 17 1946,  
 and that I last saw him alive on Apr. 17 1946.

Immediate cause of death Chronic myocarditisDue to Acute changes

Due to

Other conditions Atherosclerosis

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

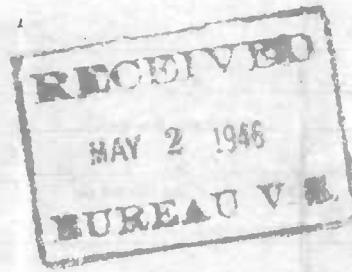
Means of Injury Injured at work?23. SIGNATURE *R. H. Henning, M.D.*

M. D. or other

Address Catonsville 28, Md. Date signed 4/17/46

VS A15 T





## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 2

## CERTIFICATE OF DEATH

113577

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County BaltimoreCity or town Sparrows Point

(If outside city or town limits, write RURAL NEAR and give town)

Street address, Hospital, or Institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

## 3. (a) FULL NAME

Frederick W. Yeager

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male

white

married

6 (b) Name of husband or wife

Mary E. Yeager

6(c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.)

January 25, 1883

8. AGE: Years

Months

Days

If less than one day

63

hrs.

min.

9. Birthplace

Pennsylvania

(Town, county, and state)

10. Usual occupation

Moulder

11. Industry or business

Beth Steel Co.

12. Name

William Yeager

13. Birthplace

Pennsylvania

14. Maiden name

Mary Kaldwasser

15. Birthplace

Pa

16. Informant

Mr. Frederick Yeager

Address

720 1st St. Sparrows Point

17. Burial

Date thereof

4/30/46

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

East Harrisburg Cem.

Location

Harrisburg, Pa

18. Funeral director

John J. Hensley, Inc.

Address

715 Eighth St.

19. Date rec'd by registrar

4/29/46

Date rec'd by registrar

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MdCounty BaltimoreCity or town Sparrows Point

Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

## 3. (b) Social Security Number

213-09-0573

## MEDICAL CERTIFICATION

2D. DATE OF DEATH

April 21

1946, at 7:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 1946, to April 27, 1946, and that I last saw him alive on April 26, 1946.

Immediate cause of death

Coronary OcclusionDue to Atherosclerotic Heart Disease

?

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings:

Of operations

Of autopsy

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work

23. SIGNATURE

John J. Hensley, Inc.

M. D. or other

Address 520 D St. Sept 19Date signed 4/26/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1246

03578 P

## CERTIFICATE OF DEATH

Reg. Dlat. No. 30

## 1. PLACE OF DEATH:

County.....

BALTIMORE

City or town.....

CATONSVILLE

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

16 days

Hospital, institution, or street address where death occurred:

HAIRLEM LODGE

How long in hospital or institution?.....

16 days

## 3. (a) FULL NAME

DOMINICA

ZIELACHOWSKI  
Zelichowska

## 3. (b) Social Security Number

4. Sex

FEMALE

5. Color or race

WHITE

6.(a) Single, married, widowed, or divorced

WIDOWED

6.(b) Name of husband or wife.....

6.(c) If alive, give age..... years

7. Birth date of

deceased (mo., day, yr.)

1889

8. AGE:

Years  
56

Months

Days

It less than one day

hrs. min.

9. Birthplace.....

POLAND  
(Town, county, and state)

10. Usual occupation.....

TAVERN OWNER

11. Industry or business

ENTERTAINMENT

MOTHER FATHER

12. Name.....

Mariaj Kasmackiewski

13. Birthplace.....

Poland

14. Maiden name.....

Sophia Rogalska

15. Birthplace.....

Poland

16. Informant.....

Stanislaus Zelichowski

Address

710 S. Bond Street

17. Burial

(Burial, cremation, or removal, which?)

Date thereof.....  
(month) (day) (year)  
4 - 17 - 46

Cemetery or crematory

Holy Rosary Cem.

Location.....

Balto. County

18. Funeral director.....

John M. Weber

Address

401 J. Chester Street

19. Date rec'd by registrar

4-16-46 Accepted

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... MARYLAND County.....

City or town..... BALTIMORE

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 710 S. BOND STREET

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... April 13

1946 at 7:35 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

MARCH 29 1946 to April 13 1946

and that I last saw her alive on April 13 1946

Immediate cause of death.....

CARDIAC D.E. COMPENSATION

DURATION

4 hrs

Due to..... ABDOMINAL ASCITES

3 WKS.-PLUS

Due to..... CIRRHOSIS LIVER

2

Other conditions.....

MENTAL DETERIORATION

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE

Arthur J. Millolland MD

Agarlem Lodge Catonsville, Md Date signed Jan 13 1946

Address.....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

03579

44

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH

County

City or town

Baltimore

Towndale 22 Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

one year

Hospital, institution, or street address where death occurred:

8500 Oakleigh Beach Rd

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed or divorced

Female

W. Presvaline infant

## 6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

April 6 - 46

8. AGE: Years      Months      Days      If less than one day

3      3      hrs.      min.

9. Birthplace

Towndale Md.

(Town, county, and state)

## 10. Usual occupation

## 11. Industry or business

FATHER

Richard George Zimmerman

MOTHER

Johnstone Pa

MOTHER

Mary Ann Swain

MOTHER

Oakdale Pa

MOTHER

Richard George Zimmerman

MOTHER

8500 Oakleigh Beach

MOTHER

Bunst

MOTHER

Data thereof: Apr 12 1946

MOTHER

(Burial, cremation, or removal. Which?)

MOTHER

(month) (day) (year)

MOTHER

Cemetery or crematory

MOTHER

Old Franklin Rd - Baltimore

MOTHER

Location

MOTHER

Harrowell Cemetery

MOTHER

Address

MOTHER

4101 Edmonson Ave

MOTHER

Date rec'd by registrar

MOTHER

April 11 - 46 Dawson J. Harber

MOTHER

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

Bells

Bells

8500 Oakleigh Beach

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

April 9 - 1946 at 11<sup>30</sup> M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 6 - 1946 to April 9 - 1946

and that I last saw her alive on April 9 - 1946

Immediate cause of death

Premature infant

4 $\frac{1}{2}$  lbs.

DURATION

3 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Dawson J. Harber M. D. or other

Address: Sparrow Point 19 Md Date signed 4/11/46

